RULE ADOPTIONS

HEALTH AND SENIOR SERVICES

SENIOR SERVICES BRANCH

DIVISION OF SENIOR BENEFITS AND UTILIZATION MANAGEMENT

Readoption and Adopted Recodification with Amendments: N.J.A.C. 10:63 as N.J.A.C. 8:85

Adopted Repeals: N.J.A.C. 10:63-1.8, 1.11, 3.22, 3.23 and 3.24, and Appendix O

Adopted Repeals and New Rules: N.J.A.C. 8:85-1.8 and Appendices A through N, P through Q

Adopted New Rules: N.J.A.C. 8:85 Appendices R, S and T

Long-Term Care Services

Proposed: October 18, 2004 at 36 N.J.R. 4700(a) (see also 37 N.J.R. 1185(a)).

Adopted: October 6, 2005 by Fred M. Jacobs, M.D., J.D., Commissioner, Department of Health and Senior Services.

Filed: October 18, 2005, as R.2005 d.389, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3), **and with proposed amendments not adopted at N.J.A.C. 8:85-1.14(a)2iii and 3.13(c).**

Authority: N.J.S.A. 30:4D-6(a)(4)(a), b(14), 30:4D-7, 7(a), (b), and (c); 30:4D-6.7, 6.8, and 12; 42 U.S.C. §1396a(a)(13)(A); 42 U.S.C. §1396r; and Executive Reorganization Plan 001-1996.

Effective Date: October 18, 2005, Readoption;

January 17, 2006, Recodification, Amendments, Repeals, and New Rules.

Expiration Date: October 18, 2010.

Summary of Public Comments and Agency Responses:

The Department received written comments from the following persons:

1. Ms. A. Katherine Blissit, Health Care Resources, Princeton, NJ;

2. Diana L. Bowen, Esq., Director, Legal and Governmental Affairs, Health Care Association of New Jersey, Hamilton, NJ;

3. Francis J. Byrne, Vice President for Public Policy, New Jersey Association of Non-Profit Homes for the Aging, Princeton, NJ;

4. Theresa Edelstein, Vice President, Continuing Care Services, New Jersey Hospital Association, Princeton, NJ; and

5. Roseann Marsicano, President, Depaul Health Care, Blue Bell, PA.

The numbers in parentheses after each comment correspond to the comment numbers above and indicate the persons who submitted the comment.

Recodification of N.J.A.C. 10:63 to 8:85

1. COMMENT: We acknowledge the appropriateness of transferring the Medicaid NF regulations to the Department of Health and Senior Services' Title of the New Jersey Administrative Code. We recognize that most of the proposed changes and additions are either technical in nature or are designed to clarify current policy and practices and will help both the State and long-term care facilities be more efficient and productive. (2)

RESPONSE: The Department thanks the commenter for its support of the proposed recodification of the chapter and the proposed technical amendments.

2. COMMENT: We thank the Department for drafting the comprehensive regulations and for the opportunity to comment on the proposal. In general, we believe that the consolidation and streamlining of the regulations as proposed will better serve the Department, the provider community, and Medicaid beneficiaries throughout the State. (3)

RESPONSE: The Department thanks the commenter for its support of the proposal.

N.J.A.C. 8:85-1.2 Definitions

3. COMMENT: Proposed N.J.A.C. 8:85-1.2 would add the definition for "beds" or "licensed beds" as the "total number of beds on the facility's license/certification." Could the Department explain how or if this definition would impact current practice of the Department regarding treatment of "beds in service" versus "beds not in service." This definition could have a significant

negative impact on facility reimbursement and other areas. We oppose adoption of this language without full explanation of the impact of this definition. (2)

4. COMMENT: The proposed definition of "beds" or "licensed beds" at N.J.A.C. 8:85-1.2 does not reflect current Department policy relative to the removal of inactive beds from a facility's license for purposes of the calculation in N.J.A.C. 8:85-1.5 and 3.16. The proposed changes to the definition, and/or the references to licensed beds in these subsections, should state "the total number of 'active' beds on a facility's [certificate] license 'as determined by the Long-Term Care Licensing Program.'" We also recommend deletion of the word "certificate" as it has no relationship to these calculations, and the number of Medicaid certified beds could legally be less than the license, although Department policy does not allow this presently. (3)

RESPONSE TO COMMENTS 3 AND 4: The Department has determined that the definition of "beds" or "licensed beds" at proposed N.J.A.C. 8:85-1.2 is potentially in conflict with the definition of this term provided at N.J.A.C. 8:39-1.2 which could result in confusion or ambiguity. N.J.A.C. 8:39 governs the licensure of long-term care facilities, and contains the rules and standards intended for long-term care facilities for use in State surveys and any ensuing enforcement actions. In contrast, proposed N.J.A.C. 8:85 addresses the provision of NF services to Medicaid eligible adults and children and reimbursement for NF services to qualified providers, not the operations and facilities standards applicable to long-term care facilities that are set forth at N.J.A.C. 8:39. Pursuant to N.J.A.C. 8:39 the Department issues a license to a facility to operate a specific number of beds. The Department has determined to defer to the licensure standard in this instance and adopt a uniform definition of the term "bed" or "licensed bed," since the number of operating beds is based on a license. Therefore, the Department will not adopt the definition as proposed and instead will amend the definition upon adoption to provide a cross-reference to the definition provided at N.J.A.C. 8:39-1.2.

5. COMMENT: The proposed addition of the term "material fact" to the list of definitions at N.J.A.C. 8:85-1.2 is not explained. There appear to be no references or changes in the proposal that would help explain the addition of this term. Could the Department explain the circumstances and motivation for this new language? (2)

RESPONSE: The form provided at Appendix B entitled "Nursing Facility Participation Agreement (PE-3)" uses the term "material fact" at item 19. The Department determined that it would be appropriate to provide the regulated community with guidance as to the Department's interpretation of this term.

6. COMMENT: Please clarify whether the proposed definition of "professional staff designated by the Department" at N.J.A.C. 8:85-1.2 would include hospital discharge planners and/or case managers who perform

assessments and counseling if and when the preadmission screening process evolves to include having these hospital staff members completing the PAS. (2, 4)

7. COMMENT: The change within the definition of "pre-admission screening (PAS)" at N.J.A.C. 8:85-1.2 to allow "professional staff designated by the Department" and further defining such to include a "professional social worker" is a positive change and will assist to expedite what is sometimes a very slow process. We recommend that the definition of "professional staff designated by the Department" be expanded to specifically include hospital discharge planners. (3)

RESPONSE TO COMMENTS 6 AND 7: The Department intends the proposed definition of "professional staff designated by the Department" at N.J.A.C. 8:85-1.2 to refer to registered nurses and professional social workers employed by the Department to conduct PAS. The Department declines to adopt the commenters' suggestion that the Department delegate the conduct of PAS to persons other than employees of the Department. The Department administers the Medicaid program through a delegation of authority from the Department of Human Services, which is the entity designated by the State as the "Single State Agency" to serve as liaison with the Centers for Medicare and Medicaid Services (CMS) of the US Department of Health and Human Services for Medicaid administration. To expedite the PAS process, the Department routinely conducts in-service training and other outreach activities at hospitals and other health care facilities to assist staff in identifying those persons at risk for NF placement, through use of the At-Risk Criteria for NF Placement provided at proposed Appendix J.

N.J.A.C. 8:85-1.3 Program participation

8. COMMENT: Amended language provides for the submission of a "Cost Report for Nursing Facility form Version 5.0" in order to establish NF per diem rates. We suggest that the reference to the "Version 5.0" be deleted in order to allow for future technical revision to the Cost Report form without having to amend the regulations. (2)

9. COMMENT: This provision makes specific reference to "Version 5.0" of the Cost Report for Nursing Facility form. We recommend that the specific version be omitted from the regulation since this is likely to change prior to the next readoption of these regulations. (4)

RESPONSE TO COMMENTS 8 AND 9: The Department agrees with the suggestion. The Department will amend proposed N.J.A.C. 8:85-1.3(a)4 upon adoption to delete references to "version 5.0" and will require that the cost study be in the form required by the Department. This would permit simpler amendment of references to this form as may be necessary in subsequent

rulemaking. The Department will also make a technical correction to the rule to reflect the accurate name of the form provided at Appendix D. In addition, the Department will not adopt the proposed new text describing the form, as this text is confusing and redundant of the existing text in this paragraph and at N.J.A.C. 8:85-1.3(a). The Department uses the information provided in this form for the purposes and in accordance with the procedures articulated in the rules at Subchapter 3, Cost Report, Rate Review Guidelines and Reporting System for Long-Term Care Facilities.

N.J.A.C. 8:85-1.5 Medicaid occupancy level

10. COMMENT: A proposed amendment at N.J.A.C. 8:85-1.5(a) would delete the phrase "and public assistance recipients" from the formula for calculating NF Medicaid occupancy. We assume that this change is being done to make the formula consistent with current policy. Several years ago "general assistance recipients" were transferred to the Medicaid Program and now appear in the count of Medicaid recipients in the calculation of a facility's Medicaid occupancy. We request that the Department confirm this as the reason for this change. (2)

RESPONSE: The Department and the industry generally use the term "beneficiaries" to refer to persons receiving Medicaid assistance. The phrase "public assistance recipients" is no longer in use.

Prior to 1996, eligibility for Medicaid was "linked" to eligibility for Aid to Families with Dependent Children (AFDC), and families that received AFDC automatically received Medicaid. In 1996 Congress repealed AFDC and established the block grant program Temporary Assistance for Needy Families (TANF). The Work First New Jersey Act, Public Law 1997 c. 13, c. 14, c. 37, and c. 38, established the Work First New Jersey Program (WFNJ), which is New Jersey's assistance component of TANF, and expands the foundation of the basic principles set forth in the Federal Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, Public Law 104-193. However, Congress also intended to protect access to Medicaid and assure that eligibility restrictions for state TANF programs would not lead to a loss of Medicaid. Therefore, Congress "de-linked" TANF cash assistance and Medicaid. As a result, Medicaid remains an individual entitlement, the receipt of which is not "linked" to the receipt of cash public assistance benefits.

N.J.A.C. 8:85-1.6 Termination of a Medicaid NF provider agreement

11. COMMENT: Proposed N.J.A.C. 8:85-1.6(a)1ii is not consistent with 42 CFR §488.412, which permits the State to continue the provider agreement for up to six months if deficiencies do not pose immediate jeopardy. The Department should conform this rule (limiting non-compliance prior to termination

to only 90 days) to the Federal certification and enforcement requirements allowing 180 days, which is current Department and CMS procedure. (3)

RESPONSE: 42 CFR §488.412(a) provides: "If a facility's deficiencies do not pose immediate jeopardy to residents' health or safety, and the facility is not in substantial compliance, CMS or the State may terminate the facility's provider agreement or may allow the facility to continue to participate for no longer than 6 months from the last day of the survey" under certain conditions. Thus, the Federal standard authorizes the Department, acting on behalf of CMS to ensure compliance with Federal NF certification requirements, to allow a NF found to be in noncompliance to continue to operate no more than 180 days. However, the Federal standard does not prohibit the State from allowing such continued operation for fewer than 180 days, and, in fact, authorizes the State to terminate the facility's provider agreement with no "grace period" whatsoever. The Federal standard permits, but does not require, amendment as suggested by the commenter. Therefore, proposed N.J.A.C. 8:85-1.6(a)1ii is consistent with the Federal standard. Furthermore, proposed N.J.A.C. 8:85-1.6(a)1ii would articulate the substantive provisions of existing N.J.A.C. 10:63-1.6(a)1ii without change.

The Department believes that enforcing the 90-day rule, as required by proposed N.J.A.C. 8:85-1.6(a)1ii, would work an unwarranted hardship on NFs in noncompliance and on the beneficiaries residing therein, and would be administratively unworkable for the Department. Ninety days may not be sufficient time for NFs to correct some types of deficiencies and for the Department to conduct the necessary follow-up inspection and to process administratively a finding that the NF has corrected deficiencies and is in compliance. Adherence to the 90-day rule would require funding to cease for beneficiaries residing in NFs as to which the Department has terminated the provider agreement, thereby forcing these beneficiaries to relocate.

This would impose an unjustified and untenable burden on these beneficiaries, especially when, as is the case in many instances, the deficiency is of a minor or technical nature that does not impinge on the quality of the beneficiary's care. Likewise, when the deficiencies are of a minor or technical nature, termination would impose an unwarranted administrative burden upon NFs to initiate application procedures toward the institution of a new provider agreement. Moreover, during a period of termination, a NF operator might not have sufficient income to maintain the NF and to retain staff while waiting for review of an application to establish a new provider agreement.

For the foregoing reasons, and as requested by the commenter, the Department will amend N.J.A.C. 8:85-1.6(a)1ii upon adoption to replace "ninety" with "180" days.

N.J.A.C. 8:85-1.8 Pre-Admission Screening (PAS), admission, and authorization

12. COMMENT: We object to an obvious change in emphasis reflected particularly in the proposed language consolidating N.J.A.C. 8:85-1.11 into N.J.A.C. 8:85-1.8. Language in this proposal evidences a bias against the quality and desirability of nursing home placement. It is apparent that if there is any opportunity for placement in a non-nursing home setting, the regulations will direct the Department to move residents from nursing facilities whether or not alternative placement provides improved quality of care, is more cost-efficient, or is contrary to patient-directed care planning. We recognize that there are a variety of options for long-term care. However, this provision of the regulations is intended to guide Department personnel in directing long-term care placement. We feel that it ignores important considerations in this process, that is, quality of care, financial impact on the State, and the important role that beneficiaries and their families play in determining a plan of care. (2)

RESPONSE: The Department appreciates the concerns and objections of the commenter; however, the Department disagrees with the conclusion that language evidences a bias against NF placement. The commenter identifies no example in the existing or proposed rules evidencing this perception of bias. The Department intends and perceives no such bias. Rather, the rules proposed for readoption and the proposed recodification, amendments, repeals and new rules at N.J.A.C. 8:85 address and reflect the important interests and concerns described by the commenter. The scope of N.J.A.C. 8:85 at proposed N.J.A.C. 8:85-1.1 addresses the provision of quality, cost-prudent health care services that are required to meet an individual's medical, nursing, rehabilitative and psychosocial needs to attain and maintain the highest practicable mental and physical functional status. Proposed N.J.A.C. 8:85-1.8(d) would require professional staff designated by the Department to evaluate an individual's care needs to determine the appropriate setting for the delivery of services. A component of such placement determinations, pursuant to proposed N.J.A.C. 8:85-1.8(d), would require professional staff designated by the Department to assign a track of care. The track of care would be designated based on the criteria for either Track I, Track II or Track III pursuant to proposed N.J.A.C. 8:85- 1.8(e). The substantive provisions of N.J.A.C. 8:85-1.8(e) respecting the track of care are substantially identical to the provisions of existing N.J.A.C. 10:63-1.11(c) in that each of the respective provisions require State professional staff, through PAS, to designate the setting and scope of Medicaid services for an individual. Tracks I and II at proposed N.J.A.C. 8:85-1.8(e) are each designations of NF placement but both Track I and Track II include discharge planning for an individual, if appropriate. A Track III designation means that, even though an individual may require NF level of care, he or she could receive such supportive healthcare services in the community. The Department's expressed and implied policy is to provide beneficiaries and their families with a variety of options for long-term care with the objective of helping beneficiaries secure placement in the most appropriate, least restrictive environment for their individualized needs. Upon adoption, the Department will relocate the description

of tracks of care I, II, and III provided at proposed N.J.A.C. 8:85-1.8(e) to the definition of "track of care" at proposed N.J.A.C. 8:85-1.2.

13. COMMENT: In proposed N.J.A.C. 8:85-1.8(b), the language restates the current policy that Medicaid payments will not be made for any care rendered before the completion of an assessment (PAS). In the past this prohibition has been waived on a case-by-case basis. When a facility submitted proof that a delay was caused by misrepresentation or omission by the resident or a third-party representative of the resident regarding the resident's prospective Medicaid eligibility, the penalty was waived and a period of pre-assessment care would be reimbursed by Medicaid as a matter of equity to the facility. Several years ago, we approached the Department about codifying this exception into the regulations. At that time, the Department stated that it preferred not to formalize the exception into the regulation, but was willing to continue making exceptions on a case-by-case basis as warranted by the factual circumstances of individual cases. We request that the Department acknowledge the continued policy of recognizing exception to the prohibition of pre-assessment payments by Medicaid on a case-by-case basis. (2)

RESPONSE: The commenter is incorrect that the Department has a policy whereby, due to a "misrepresentation or omission by the resident or a third party representative of the resident regarding the resident's prospective Medicaid eligibility" to the facility, exceptions are made to the PAS requirement that would allow Medicaid payments for services rendered prior to the completion of the PAS. Proposed N.J.A.C. 8:85-1.8(a) would provide that a Medicaid participating NF would not admit any individual who is financially eligible for Medicaid or who may become financially eligible for Medicaid within 180 days of admission to the facility, or an individual who meets the Pre-Admission Screening and Resident Review (PASRR) requirements, unless that individual were prescreened by professional staff designated by the Department and determined appropriate for NF placement. Further, proposed N.J.A.C. 8:85-1.8(b) would provide that the New Jersey Medicaid Program would not pay for NF services provided to private paying residents who have applied for Medicaid benefits unless such individuals had been authorized to receive NF services through the PAS. Proposed N.J.A.C. 8:85-1.8(a) and (b) are restatements of the substantive provisions of existing N.J.A.C. 10:63-1.8(e) and (h). Therefore, it is not the policy of the Department, and it will not be the policy of the Department going forward, to make an exception to the PAS requirement and make retroactive payments in the manner requested by the commenter.

N.J.A.C. 8:85-1.9 Waiting list

14. COMMENT: The addition of language to allow "transfers from another nursing facility" is a positive change and will assist in timely and appropriate admissions and discharges for providers and beneficiaries. (3)

RESPONSE: The Department thanks the commenter for its support of the proposed amendment at N.J.A.C. 8:85-1.9.

15. COMMENT: Proposed N.J.A.C. 8:85-1.9 would provide for the establishment of admission waiting lists. The proposal would add "transfers from another nursing facility" to a list of apparent exceptions to a waiting list priority (exceptions currently include emergency, life threatening situations, or life-care community admissions). It appears that this addition would give a facility the discretion to admit transferred residents before other persons on the waiting list. We request that the Department clarify whether this exception would be discretionary. If it were interpreted to be mandatory, we would object to this proposed change. (2)

16. COMMENT: Please clarify the intent behind the addition of "or transfers from another nursing facility." Specifically, what is the Department's expectation with regard to how residents who are being transferred will be treated as opposed to those on the facility's waiting list? (4)

RESPONSE TO COMMENTS 15 AND 16: The Department intends and expects the proposed amendment at N.J.A.C. 8:85-1.9(a) to authorize facilities to use discretion in determining to admit transfer residents before other persons on a waiting list.

N.J.A.C. 8:85-1.10 Involuntary transfer

17. COMMENT: This provision has a new proposed requirement that facilities send a copy of a 30-day written notice of involuntary transfer to the Office of the Ombudsman for the Institutionalized Elderly, in addition to the Long-Term Care Field Office. We object to the required notice to the Ombudsman for all involuntary transfers. The licensing regulations already require that formal written notice to a beneficiary of an involuntary transfer is to include contact information for the Ombudsman. N.J.A.C. 8:39-4.1(a)32. In addition, the Long-Term Care Field Office could notify the Ombudsman if an issue of resident abuse arises. It does not seem productive to send notice of every instance of involuntary transfers of Medicaid residents when only a very small number of such cases may ever involve resident abuse. We respectfully recommend removing the Ombudsman from this provision as it is duplicative and unnecessary. Please explain the rationale for proposing this additional requirement. (2, 4)

RESPONSE: The Department acknowledges that an NF's initiation of an involuntary transfer, in and of itself, does not give rise to a justifiable inference of abuse. The Department intends the proposed amendment at N.J.A.C. 8:85-1.10(g)2, requiring a facility initiating an involuntary transfer to send a copy of the 30-day notification to the Ombudsman, to be a means of providing an additional safeguard to protect the rights of the frail elderly.

Proposed N.J.A.C. 8:85-1.10(g)2 would require NFs to send a transfer notice to the beneficiary and to the LTCFO after the LTCFO determines that the beneficiary transfer is appropriate. Therefore, the Department does not believe that requiring the NF to forward an additional copy of the transfer notice to the Ombudsman is burdensome. The Department believes that direct notice to the Office of the Ombudsman would provide a reasonable additional layer of protection from abuse for institutionalized elderly Medicaid beneficiaries. For the foregoing reasons, the Department declines to delete the proposed amendment upon adoption, as requested by the commenters.

N.J.A.C. 8:85-1.14 Absence from facility due to hospital admission or therapeutic leave; bed reserve

18. COMMENT: New language at proposed N.J.A.C. 8:85-1.14(a)2ii would preclude Medicaid reimbursement for bed reserve when NF per diem payment is being made by a third-party insurer. Medicaid law has always provided that the Medicaid program is the last payer for health care services to eligible beneficiaries, and legally liable third parties have always been held accountable for payment before Medicaid liability arises. Could the Department explain the circumstances for emphasizing the liability of third-party insurers in bed hold situations? (2)

RESPONSE: The commenter is correct; the proposed amendment at N.J.A.C. 8:85-1.14(a)2ii would emphasize that Medicaid is the payer of last resort and will not pay where other insurance is available. This is consistent with the Legislature's expression of its intention in promulgating the Medicaid enabling legislation. N.J.S.A. 30:4D-2 provides in part: "It is the intent of the Legislature that benefits provided [under that statute] shall be last resource benefits notwithstanding any provisions contained in contracts, wills, agreements or other instruments." The Department has determined that it is appropriate to articulate this in rule form to ensure that regulated entities have notice of this longstanding requirement.

19. COMMENT: Proposed N.J.A.C. 8:85-1.14(a)2iii would preclude a facility from billing Medicaid for a new bed hold period (that is, eligibility for payment of an additional 10 bed hold days) unless a resident returning from a hospital stay remains at the NF for at least 24 hours. Current practice of the Department precludes eligibility for reimbursement for an additional 10 bed hold days if the resident returned to the hospital before midnight of the day of readmission to the NF. We request that the Department incorporate the current practice into regulation (that is, precluding an additional bed hold period if the resident returns to a hospital before midnight of the day of return to the NF). We suggest that the current procedure will be easier to administer/monitor for both the State and the facilities and is consistent with standard billing practices.

Regardless of the Department's reason for the proposed change, only clinical considerations should be relevant in the timing of admission/readmission to a hospital. The number of bed hold days paid by Medicaid ranges from one to three percent of any facility's total days. The number of bed hold days related to near-contiguous hospital stays is only a small percentage of total bed hold days. We suggest that imposing a fiscal penalty for such an infrequent occurrence is not good public health policy. In addition, if a facility were somehow "gaming" the system in order to enhance revenues, this would be obvious as a pattern and could be handled on audit on a case-by-case basis.

If the proposed change is not revised, we request that some ancillary issues be clarified upon adoption. We would anticipate that if a resident returned to a hospital within 24 hours of returning to the NF, the facility should be able to bill Medicaid at the full per diem rate if the resident was in the NF at midnight and, subsequently, at the bed hold rate for any remaining bed hold eligibility from the prior hospital admission. (2)

20. COMMENT: Clarification needs to be made at proposed N.J.A.C. 8:85-1.14(a)2iii that the transfer back to the NF from the hospital is being made during a 10-day bed reserve period for the new 24-hour length of stay requirement to take effect. Any transfer from a hospital back to a NF after the 10-day bed reserve should not be subject to a 24-hour rule since the NF is not required to reserve the bed past the 10-day period. (3)

21. COMMENT: Please explain why a Medicaid beneficiary who is transferred back to an NF and then readmitted to a general or psychiatric hospital must have been in the NF for 24 hours before being readmitted to the hospital to qualify for another 10-day bed reserve. All billing regulations are based on whether the patient occupied a bed at midnight. We respectfully recommend that if a Medicaid beneficiary who is transferred back to a NF from a hospital is then readmitted to the hospital should qualify for an additional 10-day bed reserve if the beneficiary occupied the NF bed at midnight prior to readmission to the hospital. A change to require a 24-hour stay would mean that new procedures would be necessary for counting eligibility for bed reserve days, as opposed to eligibility for billing for an inpatient day. (4)

22. COMMENT: We object to the proposed change in bed hold regulations at proposed N.J.A.C. 8:85-1.14(a)2iii that would require a Medicaid beneficiary to be in a nursing facility for at least 24 hours before being eligible for a new 10-day bed hold state. All other billing regulations are based on the "midnight rule," that is, if a patient is in a bed at midnight, the facility receives payment, otherwise the facility does not receive payment. We propose that the midnight rule be applied to the question of whether or not a new bed hold stay begins.

When a beneficiary is readmitted to the NF from the hospital, say at 3:00 P.M. on a Monday, then is readmitted to the hospital the following morning at 10:00 A.M., the NF will properly bill for an inpatient day for Monday. Facility systems, and the UNISYS system are currently set to restart the 10-day eligibility. Changing this regulation to require a 24-hour stay will require facilities to implement new procedures for distinguishing this inpatient day which does not restart the eligibility from another one-day stay that would restart the eligibility. It would also require a new billing mechanism to inform UNISYS of the difference in the two inpatient days. Just as with other billing, there will be times when a facility benefits by the midnight rule, but these will be offset by the times when the patient is not present at midnight. We ask that you modify this proposed change to be consistent with other billing procedures. (1)

RESPONSE TO COMMENTS 19 THROUGH 22: The 10-day bed hold allows a facility to receive Medicaid reimbursement at 90 percent of the NF per diem rate for 10 days from the date a beneficiary transfers to a hospital, in order to retain the beneficiary's ability to return to the same NF bed after the reasons for the transfer to the hospital have resolved. However, P.L. 2005, c. 132, An Act making appropriations for the support of the State Government and the several public purposes for the fiscal year ending June 30, 2006 and regulating the disbursement thereof, approved July 2, 2005 (SFY 2006 Appropriations Act) provides that, effective July 1, 2005, through June 30, 2006, reimbursement for nursing facility services shall be 50 percent of the per diem rate when a Medicaid beneficiary is hospitalized.

The so-called "midnight rule" provides that if the beneficiary returns from the hospital to the NF by midnight of the 11th day after the transfer to the hospital, the facility can start a second 10-day period of bed hold reimbursement, even if the beneficiary requires retransfer back to a hospital on the 12th day.

While the Department is unable to locate a Federal source from which the so-called "midnight rule" became part of New Jersey Medicaid policy, the rule has existed either formally or informally in New Jersey for at least three decades. The midnight rule came into effect at a time when Medicaid beds were scarcer than they are today, and failure to have a bed hold in place could mean that a beneficiary's hospital discharge could be delayed until a new NF placement could be located.

The proposed amendment at N.J.A.C. 8:85-1.14(a)2iii, the "24-hour rule," would provide that the discharge of a beneficiary from a hospital back to a NF on the 11th day in time to restart a second 10-day bed hold reimbursement clock would not restart the clock unless the beneficiary remained at the NF for 24 hours before being readmitted back to a hospital.

The commenter is correct in stating that only clinical considerations should be relevant in the timing of hospital discharges and readmissions. However,

inasmuch as the demand for NF beds is not what it was in years past, in proposing the amendment, the Department sought to save the Medicaid program the expense of a second 10-day bed hold when it is probable that the Medicaid bed would be available for the beneficiary regardless of whether the bed was reserved.

At this time, the Department will not be adopting the proposed amendment at N.J.A.C. 8:85-1.14(a)2iii establishing the 24-hour rule, for several reasons. The commenters are correct in their assertion that the proposed amendment would require an extensive industry-wide investment in modifying the culture of NF and hospital staff who are used to the decades-old midnight rule.

Moreover, the proposed amendment would require specific tracking of a beneficiary's whereabouts over a 24-hour period. The Department acknowledges difficulties with this requirement. For example, ambiguity could arise with respect to where a beneficiary is deemed to be located while in transit.

In addition, the Department has obtained initial estimates indicating that the investment necessary to rewrite the programming of the UNISYS billing agent to accommodate payment in accordance with the proposed amendment could be greater than the intended savings to the Medicaid system of the proposed amendment.

For these reasons, the Department has determined not to adopt the proposed amendment at N.J.A.C. 8:85-1.14(a)2iii at this time. The Department will continue to monitor provider activity and will take appropriate action when it becomes aware of improper transfer activity.

On adoption, the Department will change the percentage reimbursement for bed-hold days from 90 to 50 to conform to the requirements of the SFY 2006 Appropriations Act.

N.J.A.C. 8:85-1.16 Utilization of resident's income for cost of care in the NF and for PNA

23. COMMENT: New language at proposed N.J.A.C. 8:85-1.16(b)2 states that a facility cannot end NF billing prior to a resident's termination of eligibility. This appears to be a corrective measure in response to a billing practice employed by some facilities related to the timing of the termination of Medicaid billing and the availability of resident income to offset Medicaid payments.

If a resident dies or is otherwise "discharged" from a facility in the first few days of the month and the facility bills Medicaid for those days, the Medicaid billing system "recovers" the full amount of resident's available monthly income even if the income amount exceeds the total Medicaid payment amount. For

example, if a resident dies on the third day of a billing month, Medicaid incurs two days of per diem liability, for example, $ 280.00. Currently, the Medicaid billing system will deduct the full amount of the resident's available income, for example, $ 880.00, from the overall Medicaid payment to the facility. In effect, the Department's current procedure incorrectly reduces the facility's current overall Medicaid receivable by $ 600.00. In order to prevent this situation from occurring, some facilities defer from billing Medicaid for the last billing month, that is, the last two days of the resident's eligibility, and recover payment for the last two days of care from the resident's available income. The balance of the monthly income would be recovered by the facility for any accumulated liability, dispersed to the resident's family or representative, or be subject to return to the State for accumulated Medicaid liability.

Technically, the State is not entitled to these "excess" funds as available income and is only contingently entitled to the funds as an estate recovery. If the proposed language is approved, facilities would continue to be under-reimbursed and, at the same time, would remain liable for these assets to the resident, or, in the case of a deceased resident, the resident's estate. We recommend that the Medicaid billing system be corrected to avoid overstating resident income liability. If this were done, the proposed amendment would be equitable to facilities and probably become unnecessary. (2)

RESPONSE: The Department intended the proposed amendment at N.J.A.C. 8:85-1.16(b)2i to address situations in which a beneficiary expires early in a month.

The Department proposed the amendment to prohibit a NF from applying a beneficiary's total monthly income turned over to a NF toward the entire balance for the last days of residency, and foregoing billing Medicaid for these days. This practice is in contravention of the Medicaid provider agreement. The Department also proposed the amendment to prohibit a NF from applying a deceased beneficiary's personal needs allowance (PNA) and available income toward an outstanding bill for the last few days during which the deceased beneficiary continued to reside in the facility, rather than submitting a bill to Medicaid for this last period of the beneficiary's eligibility.

Upon the death of a Medicaid beneficiary, the balance of the beneficiary's monthly income proceeds (minus the beneficiary's cash share per day of the NF bill, if any) and the beneficiary's PNA, being personal property, become the property of the decedent's estate. N.J.S.A. 3B:1-3. The proposed amendments would require facilities to bill Medicaid for the beneficiary's last few days of residency prior to death.

The commenter correctly notes that Medicaid billing system is set up to assume the NF has received the appropriate per diem payment of the beneficiary's cash share of the NF bill from the beneficiary's income. The system

does not have a mechanism in place to handle situations in which the NF does not receive payment for the beneficiary's cash share of the per diem amount owed. This may result in NFs being under-reimbursed for these last days of residency.

The Department is not able to undertake reprogramming the Medicaid billing system to take into account this situation. Moreover, the Department declines to adjust the proposed amendment in a way that would authorize NFs to access a deceased beneficiary's unincurred income or PNA.

Nonetheless, the Department recognizes that it is appropriate to provide NFs with a procedural remedy when a NF does not receive payment from a beneficiary's estate for the beneficiary's share of the per diem payment for the last month of the beneficiary's residency. The Department has determined to consider a proposed rulemaking to establish a procedure that would enable NFs to apply to the Department to recover corrected amounts Medicaid may owe them for the beneficiary's last days of residency.

N.J.A.C. 8:85-2.2 Delivery of nursing services

24. COMMENT: The amendments at proposed N.J.A.C. 8:85-2.2 would change the definitions of "nursing services requiring additional nursing hours" (acuities). We understand that most of these proposed changes originated from the experiences of Department staff in attempting to more precisely define acuities and avoid confusion in reporting and auditing.

Original language in proposed N.J.A.C. 8:85-2.2(a) incorporates "by reference" the Department's licensing standards for minimum nurse staffing (N.J.A.C. 8:39) into this new/transferred section of the Department's regulations. At the same time, both the proposal and the licensing standards include their own set of definitions for seven specific "nursing services requiring additional nursing hours" (acuities). The proposed changes in N.J.A.C. 8:85-2.2(f) would result in inconsistencies in the definitions between the amended sections of the regulation and the existing DHSS licensing standards. (2)

25. COMMENT: While the restructuring of proposed N.J.A.C. 8:85-2.2 appears helpful, especially the inclusion of a separate "respiratory services" section, we are concerned with some of the language changes being proposed. If adopted, these changes would be inconsistent with the requirements contained in the Standards for Licensing for Long-Term Care Facilities at N.J.A.C. 8:39-25 and, in some instances, may be in conflict with the Department's Acuity Guidance Letter issued in January 2002. (3)

26. COMMENT: While we appreciate that Medicaid regulations can be more stringent than licensing standards, we believe that having different definitions of the same acuities in two sets of standards will lead to confusion and

errors. In addition, there is also a Department guidance document on acuities from January 2002 that would not be consistent with these revised Medicaid regulations. Please explain how the Department plans to address these inconsistencies so that providers are properly informed and advised. (4)

RESPONSE TO COMMENTS 24 THROUGH 26: In addition to the basic per diem payment for services included in "NF level of nursing care" described at proposed N.J.A.C. 8:85-2.2(b) through (e), NFs can receive supplemental reimbursement for each category of additional nursing services a beneficiary requires. These categories of additional nursing services, also referred to by the commenters as "acuities" or "add-on services," are listed at proposed N.J.A.C. 8:85-2.2(a)1 through 7, and are more fully described at proposed N.J.A.C. 8:85-2.2(f)1 through 7.

The Department will amend proposed N.J.A.C. 8:85-2.2(f) upon adoption to provide a cross-reference to the services described at N.J.A.C. 8:85-2.2(b) through (e), known as services provided at the "NF level of nursing care."

Although the requirements at proposed N.J.A.C. 8:85-2.2, in addition to amendments made upon adoption, and N.J.A.C. 8:39-25 will be inconsistent, proposed N.J.A.C. 8:85-2.2 would control and would supersede N.J.A.C. 8:39-25 with regard to beneficiaries. Proposed N.J.A.C. 8:85 would provide rules relevant to beneficiaries receiving long term care services, whereas, N.J.A.C. 8:39 governs the licensure of long-term care facilities, and contains the rules and standards intended for long-term care facilities for use in State surveys and any ensuing enforcement actions. Further, N.J.A.C. 8:39 provides rules applicable to long term care facilities, which have resident populations that include beneficiaries, but are not exclusively comprised of individuals eligible to receive Medicaid funding for NF services. Therefore as previously stated, with regard to beneficiaries, proposed N.J.A.C. 8:85 would control and would supersede N.J.A.C. 8:39.

The January 2002 DHSS Acuity Guidance Letter is a guidance document that the audit unit of the Department issued with the intent of assisting NFs in complying with existing N.J.A.C. 10:63-2.2. To the extent that letter contains guidance that is inconsistent with proposed N.J.A.C. 8:85-2.2, N.J.A.C. 8:85-2.2 would control and would supersede that letter.

27. COMMENT: We request clarification as to when the Department would apply the proposed amendments at N.J.A.C. 8:85-2.2 in evaluating a beneficiary's need for additional nursing services in excess of NF level of nursing care. (1, 4)

RESPONSE: The Department has determined that the proposed recodification of N.J.A.C. 10:63 as new N.J.A.C. 8:85, and the proposed

amendments, new rules, and repeals, will be effective upon publication of the notice of their adoption in the New Jersey Register, January 17, 2006.

N.J.A.C. 8:85-2.2(f)1 Wound care

28. COMMENT: Please incorporate the use of wound vacuum therapy into the criteria at N.J.A.C. 8:85-2.2(f)1. (5)

RESPONSE: Vacuum-assisted wound therapy is a Medicare-reimbursable therapy for a specified treatment period. The Department has denied and would continue to deny reimbursement for vacuum-assisted wound therapy as an additional nursing service when a beneficiary is Medicare-eligible. As stated above, the enabling legislation for Medicaid articulates the Legislature's intention to make Medicaid the payer of "last resource." N.J.S.A. 30:4D-2. However, when a beneficiary is only Medicaid-eligible and not Medicare-eligible, the Department would reimburse for vacuum-assisted wound therapy as a type of wound care reimbursable as an additional nursing service pursuant to N.J.A.C. 8:85-2.2(f)1.

29. COMMENT: Clarification is needed as to the frequency of wound care treatments, that is, occlusive dressing use. Wound care acuities have been invalidated during audit based on lack of a "daily" treatment, although no such criteria is found in the statute. Licensed nurses assess these wounds daily for signs and symptoms of non-healing and/or infection, despite the fact that the dressing may only be changed every three days. (5)

RESPONSE: Wound care is reimbursable as additional nursing service only if the beneficiary requires 0.75 hours of wound care, pursuant to proposed N.J.A.C. 8:85-2.2(f)1, in excess of the care included in NF level of nursing care. Proposed N.J.A.C. 8:85-2.2(c) would provide that the NF level of nursing care incorporates "ongoing assessment of the beneficiary's health status for the purpose of planning, implementation and evaluating the individual's response to treatment." This includes daily wound assessment for "signs and symptoms of non-healing and/or infection." Therefore, this type of assessment is not reimbursable as an additional nursing service because it is included in NF level of nursing care.

30. COMMENT: The language in wound care at existing N.J.A.C. 10:63-2.2(g)1, proposed for recodification as new N.J.A.C. 8:85-2.2(f)1, should be expanded to define "Stage 2" as "an area marked by partial-thickness skin loss involving the epidermis, dermis or both. The ulcer is superficial and appears as an abrasion, a blister, or a shallow crater"; and to define an "anatomical site" as "the same site if multiple wounds can be covered by a unilateral dressing. Separate sites require a bilateral dressing." In other words, if the wound is bilateral, it should not be considered the same anatomical site, regardless of whether one dressing is used to cover the area. (3)

RESPONSE: The Department declines to adopt the commenter's recommendation. The commenter provides no rationale for the recommendation. Stage II pressure sores are defined at existing N.J.A.C. 10:63-2.2(f)11ii, proposed for recodification as new N.J.A.C. 8:85-2.2(e)11ii, and are included in NF level of nursing care, regardless of the number of Stage II wounds in the same anatomical site.

N.J.A.C. 8:85-2.2(f)2 Tube feedings

31. COMMENT: Proposed N.J.A.C. 8:85-2.2(f)2 defines those nursing services classified as "tube feedings." The addition of the word "only" to the provision could be construed to mean that a Medicaid resident is never to receive tube feedings unless the volume of the tube feedings meets the parameters set out in this provision of the regulations. We understand that the intention of this provision is to establish a threshold for recognition of nursing hours above the standard complement of 2.5 hours per patient per day for clinical and reimbursement purposes. It is not designed to preclude necessary nursing services. We request that this language be changed to avoid an interpretation that would prohibit tube feedings at levels below those listed in the acuity definition. (2)

32. COMMENT: The revised wording of this acuity suggests that tube feedings can only be used in the circumstances described. In fact, the wording actually means that tube feedings can only be counted as an acuity when the conditions described are met. (4)

RESPONSE TO COMMENTS 31 AND 32: The commenters are correct. The Department intends the items in proposed N.J.A.C. 8:85-2.2(f)1 through 7 to describe the categories of services that are reimbursable as additional nursing services in excess of services included in NF level of nursing care. The Department did not intend this list to dictate a course of treatment. The Department will amend proposed N.J.A.C. 8:85-2.2(f)2 upon adoption to delete the phrase "may be used." This will make the item consistent with the "list" style of the other paragraphs of subsection (f), proposed N.J.A.C. 8:85-2.2(f)1 and 3 through 7, which use no verb in the first line.

33. COMMENT: Proposed N.J.A.C. 8:85-2.2(f)2 is unclear as to whether 501 cubic centimeters or more of enteral fluid intake per day applies to both sets of calorie percentages or just the 26 to 50 percent calories. The wording should be changed to read as follows: "Tube feedings (1.00 hr/day), which include nasogastric tube and percutaneous feedings may only be counted as a nursing acuity if the feedings are providing the individual with 51 percent or more calories or 26 to 50 percent calories and 501 milliliters or more of enteral fluid intake per day; and all non-invasive avenues to provide nutritional status have been exhausted with no improvement." (4)

34. COMMENT: Proposed N.J.A.C. 8:85-2.2(f)2 regarding tube feedings is confusing since it is not clear if the "501 cubic centimeters or more of enteral fluid intake per day" is a threshold required in the "51 percent or more calories" or just the "26 to 50 percent calories" instance. We suggest the following language: "at least 26 percent of daily caloric requirements and 501 cubic centimeters fluid per day or 51 percent of daily calories. (3)

RESPONSE TO COMMENTS 33 AND 34: The Department intends the condition of 501 cubic centimeters or more of enteral fluid intake per day to apply only to the condition of 26 to 50 percent calories of enteral fluid intake per day. The Department agrees that the requirement is potentially unclear as written, and will amend proposed N.J.A.C. 8:85-2.2(f)2 upon adoption to reorganize and recodify this paragraph for precision of meaning and to provide the clarification requested by the commenters.

35. COMMENT: At proposed N.J.A.C. 8:85-2.2(f)2, we are recommending that "milliliters" be used instead of "cubic centimeters" because both the Joint Commission on Accreditation of Healthcare Organizations and the Institute for Safe Medication Practices have identified "cc" as a dangerous medical record abbreviation. Further, milliliters are the unit of measurement used in the Medicare language. (4)

RESPONSE: The Department agrees with the commenter's recommendation. "Milliliter" is the term used in the Medicare definition of tube feedings and "cubic centimeters" is subject to potentially confusing abbreviation. Upon adoption, the Department will amend N.J.A.C. 8:85-2.2(f)2 to change "cubic centimeters" to "milliliters" for the aforementioned reasons, and because one milliliter is the equivalent of one cubic centimeter.

36. COMMENT: Proposed N.J.A.C. 8:85-2.2(f)2 adds language that is similar, but not exactly the same, as the existing licensing regulation definition of tube feedings. The proposal would permit classifying a patient as having tube feedings "if the feedings are providing the individual with 51 percent or more calories or 26 to 50 percent calories and 501 cubic centimeter or more of enteral fluid intake per day." The licensing regulations currently classify as tube feedings an "individual with more than 26 percent of his or her calories and at least 501 milliliters of hydration daily." The proposed language is more inclusive than the licensing regulations. That is, it would allow residents that require tube feedings providing 51 percent or more of calories but do not receive 501 or more cubic centimeters of fluid intake per day being classified as tube feeding services. We are uncertain how much of a difference this makes clinically, that is, the number of residents receiving at least 51 percent of caloric intake but less than 501 cubic centimeters of fluid intake per day. However, we would favor the proposed language as being more inclusive and more fairly reflecting the nursing care required by residents who may be receiving these services. (2)

RESPONSE: The Department thanks the commenter for its support of the proposed amendment.

37. COMMENT: We believe that even with these suggested revisions, Medicaid will be reimbursing providers for care and services truly needed above and beyond the minimum of 2.5 hours per day to maintain the resident's highest practicable level of functioning. (4)

RESPONSE: The Department thanks the commenter for its support of the proposed amendment.

N.J.A.C. 8:85-2.2(f)3 Oxygen therapy

38. COMMENT: The proposed amendment at N.J.A.C. 8:85-2.2(f)3 changing the wording of this acuity for "oxygen therapy" would eliminate all but the most acutely ill residents with pulmonary and cardiac conditions in NFs. We recommend the following revision to this provision: "Oxygen therapy (0.75 hrs/day), which includes the provision of episodic oxygen therapy and monitoring of this therapy as prescribed by a physician to increase the saturation of hemoglobin (Hb) without risking oxygen toxicity in beneficiaries with airway obstructive conditions such as asthma, chronic obstructive pulmonary disease or other heart failure. The beneficiary requires periodic pulse oximetry monitoring as prescribed. The licensed nurses assess lung function and the beneficiary's symptoms that require intervention by the physician, physician assistant or advanced practice nurse." (4)

39. COMMENT: The proposed amendment at N.J.A.C. 8:85-2.2(f)3 defines those nursing services classified as "oxygen therapy." This definition has been revised significantly in the proposal. Most notably, it would require the provision of "**continuous** oxygen therapy" to be included in this acuity category. This restrictive language combined with the transfer of certain treatments to respiratory therapy, that is, pressure breathing therapy, Bilevel Positive Airway Pressure (Blpap), Continuous Positive Airway Pressure (CPAP), and aerosol therapy, would preclude most patients who receive other forms of oxygen therapy from being classified in the oxygen therapy category. In addition, we request that the Department clarify whether a patient would require both "continuous oxygen therapy" and "continuous pulse oximetry monitoring" concurrently in order to qualify for this acuity. If a resident needed both continuous oxygen therapy and continuous pulse oximetry monitoring to warrant additional nursing hours, this new "acute" definition in actual practice would apply only to patients requiring 24/7 nursing care and would have little applicability in a NF setting.

The parameters as set out in the proposal would significantly limit this acuity. Consequently, it greatly understates, at 2.5 hours per day, the nurse

staffing time to meet the clinical needs of many residents receiving non-continuous forms of oxygen therapy at nursing facilities. We request that the Department adopt a definition of oxygen therapy that would be appropriately inclusive, such as "patients requiring episodic oxygen therapy and monitoring for conditions such as COPD, asthma, chronic obstructive pulmonary disease, heart failure, cardiac conditions, low blood count, low blood pressure, etc." We do not feel that the language limiting this acuity to only "airway obstructive conditions" is clinically appropriate. (2)

40. COMMENT: The word "continuous" at proposed N.J.A.C. 8:85-2.2(f)3 should be deleted from the phrase "continuous pulse oximetry monitoring." A strict interpretation of this would preclude many, if not all, NFs from providing and/or receiving reimbursement for this add-on service. We suggest the following in its place: "Oxygen therapy is necessitated by an acute episode lasting more than 24 hours, requiring continuous O2 via nasal canula or mask, monitoring by the nurse, periodic pulse oximetry checks and physician notification." (3)

RESPONSE TO COMMENTS 38 THROUGH 40: In proposing new N.J.A.C. 8:85-2.2(f)3, the Department intended to reimburse episodic oxygen therapy as an additional nursing service. Episodic therapy generally requires frequent, recurring, and ongoing monitoring, and, therefore, requires more intensive nursing intervention and communication with the beneficiary's attending physician to modify orders than does constant or "continuous" oxygen therapy. The uncomplicated application of maintenance oxygen therapy without continuous pulse oximetry monitoring and assessment is not a complex provision of oxygen. Therefore, it is included in NF level of nursing care. See existing N.J.A.C. 10:63-2.2(f)13, proposed for recodification as new N.J.A.C. 8:85-2.2(e)13.

The Department, therefore, agrees with the commenters' suggestions. The Department will amend N.J.A.C. 8:85-2.2(f)3 upon adoption to add "episodic" oxygen therapy as an additional nursing service, and, inasmuch as "continuous oxygen therapy" is included in NF level of nursing care, as discussed above, will not adopt the proposed addition of the word "continuous" before the phrase "oxygen therapy." In addition, the Department will amend N.J.A.C. 8:85-2.2(f)3 upon adoption to establish that the required pulse oximetry monitoring must be "frequent, recurring, and ongoing," as the Department did not intend the required monitoring to be "continuous," inasmuch as this term means "incessant."

41. COMMENT: Please define "continuous pulse oximetry" as methodology in monitoring O2 saturation of hemoglobin in terms of frequency. Also, the duration of the therapy is not defined. The acuity has been denied on audit, based on too few consecutive days of therapy, but no criteria are found in the statute. (5)

RESPONSE: Pulse oximetry is a component of vital signs, using a mechanical device attached to a beneficiary's digit to monitor O2 saturation. The inclusion of pulse oximetry monitoring to document the need for O2 administration is required to validate the O2 administration. Pulse oximetry monitoring and assessment is used to determine the continued need for the maintenance oxygen treatment. The duration of therapy is as ordered by the physician, physician assistant or advanced practice nurse. As stated in the preceding response, the Department did not intend to require continuous or "incessant" monitoring and will amend N.J.A.C. 8:85-2.2(f)3 upon adoption to require "frequent, recurring, and ongoing" monitoring.

42. COMMENT: We believe that even with these suggested revisions, Medicaid will be reimbursing providers for care and services truly needed above and beyond the minimum of 2.5 hours per day to maintain the resident's highest practicable level of functioning. (4)

RESPONSE: The Department thanks the commenter for its support of the proposed amendment.

N.J.A.C. 8:85-2.2(f)4 Tracheostomy

43. COMMENT: Please recognize that tracheostomy care involves additional nursing hours for cleaning, dressing and assessment regardless of whether it is new or old, with or without infectious process. (5)

RESPONSE: Existing N.J.A.C. 10:63-2.2(f)12, proposed for recodification as new N.J.A.C. 8:85-2.2(e)12, would continue to provide that "long-term care of a simple stabilized tracheostomy with minimal care and supervision by licensed staff" is care included within the 2.5 hours of services provided at the NF level of nursing care. See also proposed N.J.A.C. 8:85-2.2(c), which would provide that "ongoing assessment" is included within the NF level of nursing care. The Department intends proposed N.J.A.C. 8:85-2.2(f)4 to provide for reimbursement as an additional nursing service the additional time needed to care for beneficiaries with tracheostomies that are infected, beneficiaries experiencing an unstable respiratory function, or beneficiaries who require more than normal suctioning to facilitate breathing.

44. COMMENT: At proposed N.J.A.C. 8:85-2.2(f)4, we recommend use of the word "or" rather than "and" between the words "symptomatic infections, unstable respiratory functions and deep suctioning." We think that this change would avoid confusion and more accurately and fairly reflect the types of residents needing these extra nursing services. (2)

45. COMMENT: The wording at proposed N.J.A.C. 8:85-2.2(f)4 suggests that a beneficiary would have to meet all three conditions, symptomatic infections, unstable respiratory functions and deep suctioning, to qualify for the

hours under this acuity. This would leave out significant numbers of nursing home beneficiaries who require additional nursing care. Therefore, we recommend that the "and" be changed to "or" between each of these conditions. (4)

46. COMMENT: It is not clear if the language "and deep suctioning" at proposed N.J.A.C. 8:85-2.2(f)4 is being included as a separate service allowed within the acuity or as an additional part of the requirements for the add-on. As there is no standard definition of what constitutes "deep suctioning," we recommend it be deleted. (3)

RESPONSE TO COMMENTS 44 THROUGH 46: The Department agrees that the term "deep suctioning" is subject to various interpretations. As it does with respect to oxygen therapy at N.J.A.C. 8:85-2.2(f)3, the Department intends to reimburse tracheostomy suctioning of a frequent, recurring, and ongoing nature as an additional nursing service. A tracheostomy suctioning of that nature necessitates a greater intervention on behalf of a beneficiary than that of the tracheostomy included in the nursing services that a NF would be required to provide in accordance with proposed N.J.A.C. 8:85-2.2(a). Such intervention would prove to be beneficial to a beneficiary. In response to the commenter's request for clarification, since the term "deep suctioning" was not defined and is ambiguous, and in an effort to eliminate any confusion regarding the types of additional nursing services eligible for reimbursement in connection with tracheostomy and to provide the Department's interpretation and intent with regard to additional nursing services for tracheostomy eligible for reimbursement, the Department will amend N.J.A.C. 8:85-2.2(f)4 upon adoption to delete the word "deep" and to replace it with the phrase "frequent, recurring, and ongoing" to more accurately reflect the Department's meaning and intention with respect for this provision.

The Department intends proposed N.J.A.C. 8:85-2.2(f)4 to provide for reimbursement as an additional nursing service the additional time needed to care for a new tracheostomy, or an old or new complicated case involving either symptomatic infection or unstable respiratory function, or an old or new tracheostomy requiring frequent, recurring, and ongoing suctioning. The Department agrees that the use of the word "and" in the text, as proposed, is potentially unclear. The Department agrees that the wording at proposed N.J.A.C. 8:85-2.2(f)4 suggests that a beneficiary with a complicated case would have to meet all three conditions, symptomatic infections, unstable respiratory functions and deep suctioning, to qualify for reimbursement of additional nursing hours for tracheostomy, which was not the Department's intent. The Department will recodify proposed N.J.A.C. 8:85-2.2(f)4 upon adoption by deleting the word "and" as suggested by the commenters and replacing "and" with "or" as an aid to clarity of what nursing services require additional nursing hours for tracheostomy care.

47. COMMENT: We believe that even with these suggested revisions, Medicaid will be reimbursing providers for care and services truly needed above and beyond the minimum of 2.5 hours per day to maintain the resident's highest practicable level of functioning. (4)

RESPONSE: The Department thanks the commenter for its support of the proposed amendment.

N.J.A.C. 8:85-2.2(f)5 Intravenous therapy

48. COMMENT: The reference to "elysis" at proposed N.J.A.C. 8:85-2.2(f)5 appears to be a typographical error and should be "clysis." (2)

49. RESPONSE: The commenter is correct in noting this typographical error. The Department will amend proposed N.J.A.C. 8:85-2.2(f)5 upon adoption to replace the word "elysis" with "clysis."

50. COMMENT: Proposed N.J.A.C. 8:85-2.2(f)5 defines those nursing services classified as "intravenous therapy." This acuity includes "clinically indicated therapies ordered by the physician, such as central venous lines, Hickman/Broviac catheters, heparin locks, total parenteral nutrition, clysis, hyperalimentation, and peritoneal dialysis." The proposed amendment would add new language to the definition, that is, "This includes the flushing and dressing of central venous lines." We understand that this language is being added to allow for those residents who have central venous lines that are not actively being utilized for the prescribed treatment, but have to be maintained for possible future use. We ask that the Department clarify if the specific new language, that is, "central venous lines," is intended to exclude residents who have to have intravenous lines maintained for any of the other prescribed treatments noted above. If not, we ask that the language be clarified to reflect those treatments for which the maintenance of lines would be included in this acuity. We strongly suggest that changing the proposed language to include maintenance for "all intravenous lines" would clarify this definition to more accurately and fairly reflect the types of residents needing these extra nursing services. (2)

51. COMMENT: Proposed N.J.A.C. 8:85-2.2(f)5 should be amended to read: "This includes the flushing and dressing of all intravenous lines." (4)

52. COMMENT: Please clarify if flushing a central venous line alone constitutes an acuity, or if this is in combination with medications, hyperalimentation, and total parenteral nutrition, et cetera. (5)

RESPONSE TO COMMENTS 50 THROUGH 52: The commenters misunderstand the Department's intention with respect to the proposed amendment at N.J.A.C. 8:85-2.2(f), and the Department is satisfied that revision

is necessary to ensure comprehension and precision of meaning, and to respond to the commenters' requests for clarification.

As with each of the types of care eligible for reimbursement as additional nursing services listed at proposed N.J.A.C. 8:85-2.2(f), the Department intends proposed N.J.A.C. 8:85-2.2(f)5 to provide reimbursement for intravenous therapy as an additional nursing service when the beneficiary's condition requires the NF to provide nursing interventions above NF level of nursing care. The fact that a beneficiary has a line or port, such as a central venous line, a Hickman/Broviac catheter, or a heparin lock, of itself does not require the NF to administer additional care to that beneficiary. The NF's active nursing care involvement with that line or port, as directed by the physician, gives rise to the beneficiary's additional care needs and justifies additional reimbursement.

The Department intended the proposed amendment at N.J.A.C. 8:85-2.2(f)5 to reflect that the beneficiary's line or port only gives rise to reimbursable additional nursing services when the NF is directed by the physician to provide nursing care by means of that line or port and to provide flushing and dressing to maintain the line or port for the use of the NF, or when the physician directs the NF to flush and dress the line or port to maintain it for purposes of an identified future or off-site use.

The maintenance of a line or port for future use requires the pendency of a specific treatment and a timeframe to reflect when it would be used. The Department will not reimburse as an additional nursing service line or port maintenance unless the line or port is associated with an identified treatment purpose and usage timeframe. Likewise, the fact that a beneficiary requires a therapy such as peritoneal dialysis does not justify additional reimbursement unless the NF is administering the peritoneal dialysis. It would be illogical to provide additional reimbursement if the beneficiary must travel off-site to another facility to receive the therapy. When, under the direction of the physician, a NF must administer therapies by means of total parenteral nutrition, clysis, hyperalimentation, or peritoneal dialysis, these therapies require additional care in excess of NF level of nursing care, and justify additional reimbursement. The proper administration of these therapies includes contemporaneous associated maintenance of the access aperture. No separate maintenance is required for future or off-site use. Therefore, maintenance for these types of therapies is not reimbursable as a separate additional nursing service as it may be for lines and ports.

The Department used the phrase "central venous lines" in the proposed amendment as a generic term and as if it were synonymous with "line or port." The commenters' requests for clarification indicate that the Department's use of this phrase is potentially confusing in the context of the paragraph, or that the phrase is not synonymous with "line or port."

For the foregoing reasons, and to respond to the commenters' requests for clarification, the Department will amend proposed N.J.A.C. 8:85-2.2(f)5 upon adoption to reorganize and recodify the paragraph to more accurately convey the Department's intention as described above, to replace the phrase "central venous lines" with the more generic phrase "lines or ports," and to include, as examples of lines or ports, central venous lines, Hickman/Broviac catheters, and heparin locks. In addition, the Department will add the phrase "for an identified treatment purpose and usage timeframe," to avoid the potential for abuse described above.

53. COMMENT: We believe that even with these suggested revisions, Medicaid will be reimbursing providers for care and services truly needed above and beyond the minimum of 2.5 hours per day to maintain the resident's highest practicable level of functioning. (4)

RESPONSE: The Department thanks the commenter for its support of the proposed amendment.

N.J.A.C. 8:85-2.2(f)6 Respiratory services

54. COMMENT: The proposed amendment at N.J.A.C. 8:85-2.2(f)6 would change the description of this category of nursing services from "respirator use" to "respiratory services" and correspondingly modifies the definition of this acuity. This is being done apparently in recognition that Medicaid reimbursement for respirator services is confined to Special Care Nursing Facilities (SCNFs). (2)

RESPONSE: The commenter is correct. Respirators are used only in ventilator units in SCNFs. The proposed amendment at N.J.A.C. 8:85-2.2(f)6 would more accurately describe this category of service in relation to services authorized for use in a NF.

55. COMMENT: Proposed N.J.A.C. 8:85-2.2(f)6 would appear to require increased nurse services (that is, nursing time) needed for the expanded list of services. For example, pressure breathing therapy, Bilevel Positive Airway Pressure (BiPAP), Continuous Positive Airway Pressure (CPAP) and aerosol therapy had formerly been recognized under oxygen therapy and are now included under respiratory services. We agree that the changes more accurately and fairly reflect the needs of residents receiving these types of treatment. (2)

RESPONSE: The commenter is correct; proposed N.J.A.C. 8:85-2.2(f)6 would relocate certain oxygen therapy services listed at existing N.J.A.C. 10:63-2.2(g)3. The Department thanks the commenter for its support of the proposed amendment.

56. COMMENT: The word "or" should be inserted before "aerosol therapy" at proposed N.J.A.C. 8:85-2.2(f)6 so that it will not interpreted that

aerosol therapy must be done in combination with the other treatments in order to qualify as an independent respiratory service. (2)

RESPONSE: The Department agrees with the commenter's recommendation. The Department did not intend to require the administration of aerosol therapy in conjunction with CPAP, but rather to propose these items as a list of separate examples of eligible respiratory services as to which the beneficiary is dependent upon licensed nursing staff to administer. The Department will amend proposed N.J.A.C. 8:85-2.2(f)6 upon adoption to replace the word "or" before "CPAP" with a comma, and to replace the word "and" after "CPAP" with "or," to precede "aerosol therapy." In addition, the Department will delete the word "nasal" before "BiPAP" upon adoption, because this terminology is unnecessary.

57. COMMENT: The Department should reference use of a nebulizer in context with aerosol therapy. This would distinguish "hand held" nebulizer treatments from hand held inhalation aerosol devices (puffers) that are specifically excluded in this definition. (2)

58. COMMENT: At proposed N.J.A.C. 8:85-2.2(f)5, the "hand held language" is confusing and should be eliminated. We suggest that language be added to clarify: "the administration of respiratory services by licensed nursing personnel to include nebulizer treatments which require the use of a pressurized gas source which allows for proper misting." (3)

59. COMMENT: We believe it is appropriate to include nebulizer treatments in the list of respiratory services for which an individual is dependent upon licensed nursing staff to administer. We also ask that the Department consider specifying what is mean by hand held inhalation aerosol devices. (4)

RESPONSE TO COMMENTS 57 THROUGH 59: The Department intended the proposed exclusion in the last sentence of proposed N.J.A.C. 8:85-2.2(f)6 to exclude from the list of eligible respiratory services the use of devices commonly referred to as "puffers." Puffers are hand-held inhalation aerosol devices used to deliver bronchodilators or steroids into the lungs. The user exhales and places the device in his or her mouth and inhales slowly once or twice to administer the prescribed medication. This service is included in NF level of nursing care, as a type of routine medication administration and an uncomplicated respiratory therapy requiring minimal nursing staff intervention. See N.J.A.C. 8:85-2.2(e)1 and 13. The revised language suggested by the commenter is not acceptable, because CPAP and BiPAP are not necessarily administered by means of a pressurized gas source, as they can be used with room air. The term "puffer" appears to be understood universally in the regulated community. The Department will amend proposed N.J.A.C. 8:85-2.2(f)6 upon adoption to reference "puffers," as an aid to comprehension and precision of meaning, and in response to the commenters' requests for clarification.

60. COMMENT: We believe that even with these suggested revisions, Medicaid will be reimbursing providers for care and services truly needed above and beyond the minimum of 2.5 hours per day to maintain the resident's highest practicable level of functioning. (4)

RESPONSE: The Department thanks the commenter for its support of the proposed amendment.

N.J.A.C. 8:85-2.2(f)7 Head trauma stimulation; and advanced neuromuscular or orthopedic care

61. COMMENT: We suggest that language relating to advanced orthopedic care be expanded to include: "Advanced orthopedic care includes proper alignment (that is, immobilizing devices, abductor pillows, external fixation devices, splinting devices) used in the immediate post operative period." (3)

RESPONSE: The Department declines to amend existing N.J.A.C. 10:63-2.2(g)7iii, proposed for recodification as new N.J.A.C. 8:85-2.2(f)7iii, as suggested by the commenter. The suggested language would result in the inclusion, as an additional nursing service, of services that are already included as restorative nursing functions within NF level of nursing care. See existing N.J.A.C. 10:63-2.2(e)7, proposed for recodification as new N.J.A.C. 8:85-2.2(d)7. The addition of the language suggested by the commenter would result in the over-utilization and reporting of this service by long-term care rehabilitation facilities specializing in short-term rehabilitation services for Medicare and private insurance orthopedic clients.

62. COMMENT: Please define "proper body alignment" in regards to the use of splints, abductor pillows, bledsoe braces, and external fixation devices. (5)

RESPONSE: The Department assumes the commenter is requesting the Department to amend existing N.J.A.C. 10:63-2.2(g)7, proposed for readoption as new N.J.A.C. 8:85-2.2(f)7, to include the application of splints, abductor pillows, bledsoe braces, and external fixation devices as an additional nursing service, and that the commenter is not requesting the Department to provide a definition of these devices. As stated in response to the previous comment, the use of these devices is included in NF level of nursing care as restorative nursing functions. Therefore, the Department declines to amend the rule as suggested by the commenter.

63. COMMENT: In regards to cast care, pre-existing peripheral vascular or circulatory disease should not be a prerequisite because additional nursing assessment and monitoring are required regardless of those conditions. The acuity has been invalidated upon most audits. (5)

RESPONSE: Follow-up required for uncomplicated cast care with no pre-existing vascular condition is included in NF level of nursing care as a restorative nursing function. See existing N.J.A.C. 10:63-2.2(e)7, proposed for recodification as new N.J.A.C. 8:85-2.2(d)7. Likewise, nursing assessment and monitoring are included in NF level of nursing care. See proposed N.J.A.C. 8:85-2.2(c). These are not additional nursing services.

N.J.A.C. 8:85-2.21 Special care nursing facility

64. COMMENT: Proposed N.J.A.C. 8:85-2.21(a)2 would add language that states that "a SCNF ...shall not increase its total number of licensed beds for which a SCNF rate of reimbursement is received except upon approval from the Department." We understand that the bed size of a SCNF unit/facility has always been established through the Medicaid provider agreement between the facility and the Medicaid State agency. This implicitly involves prior notice and approval by the Department. Could the Department explain the circumstances requiring the adoption of regulatory language requiring Department prior approval for SCNF bed additions? (2)

RESPONSE: The Department learned through the long-term care survey process and through cost reports submitted in connection with the rate setting process that some SCNF units were adding SCNF beds (and billing for SCNF services provided to beneficiaries residing therein) in excess of the number of licensed SCNF beds the SCNFs were authorized to have, as provided in the Medicaid provider agreement, and, when applicable, as provided in the certificate of need. The Department intends the proposed amendment at N.J.A.C. 8:85-2.21(a)2 to reinforce the requirement that a SCNF must obtain the prior authorization of the Department as to the addition of SCNF beds and further that any authorized increase must be memorialized in an amended Medicaid provider agreement and, when applicable, an amended certificate of need. Otherwise, the SCNF cannot add or bill for these additional unauthorized beds at SCNF rates. The regulated community already should know and understand this requirement, inasmuch as it is stated expressly and implicitly in the Medicaid provider agreement, and, when applicable, the certificate of need. The abusive actions of certain SCNFs to the contrary suggest that it is necessary for the Department to rearticulate this requirement in rule form. The Department will not pay SCNF rates for unauthorized SCNF beds.

65. COMMENT: Proposed N.J.A.C. 8:85-2.21(c) would add language that in an SCNF, the "individual's progress and overall response to the therapeutic regimen shall determine length of stay." We would object to any language that would limit consideration for continued SCNF stay by a resident without taking into consideration a full range of factors of the impact of a move on the beneficiary. (2)

RESPONSE: The commenter's concern is unwarranted. The Department does not intend the proposed amendment at N.J.A.C. 8:85-2.21(c) to reflect a change in existing policy. The proposed amendment would relocate almost identical text proposed for deletion from existing N.J.A.C. 10:63-2.2(a)2 to new N.J.A.C. 8:85-2.21(c). Proposed N.J.A.C. 8:85-2.21(c)1 and 2 would continue to articulate the requirement for review of SCNF admission after designated time periods. The definition of "PAS" at proposed N.J.A.C. 8:85-1.2 would continue to articulate the factors taken into account during this review. Proposed N.J.A.C. 8:85-2.21(d) would continue to articulate discharge considerations. Collectively, the cited references and other provisions throughout the chapter take into account the considerations urged by the commenter.

66. COMMENT: Proposed N.J.A.C. 8:85-2.21(e)2iii would add language that states that an SCNF that is a unit within a conventional NF "shall calculate the nurse staffing level separate and apart from the nurse staffing level of the conventional beds." We assume that this language is consistent with current Department policy for both clinical and reimbursement purposes and is being added to the regulations for clarification. Can the Department affirm or refute this assumption in this regard? (2)

RESPONSE: The Department learned through the long-term care survey process that some NFs with attached SCNF units were attempting to meet their minimum NF staffing requirements by counting toward the NF minimum those staff employed to meet the SCNF minimum, thereby resulting in facility-wide (NF and SCNF) understaffing. Again, the regulated community should have understood expressly and implicitly this requirement by virtue of the express and implied requirements contained in these rules, the Medicaid provider agreement and, when applicable, the certificate of need. The abusive actions of certain facilities to the contrary suggest that it is necessary for the Department to rearticulate in rule form the impropriety and illegality of counting SCNF nursing care personnel toward meeting NF minimum nursing care staffing requirements.

67. COMMENT: Proposed N.J.A.C. 8:85-2.21(e)2iv includes added language to the effect that "the additional nursing services (acuities) described at N.J.A.C. 8:85-2.21-2.2(a) are included in the three hours." We assume that this language is consistent with current Department policy and is being added to the regulations as clarification. Can the Department affirm or refute this assumption in this regard? (2)

RESPONSE: The proposed amendment at proposed N.J.A.C. 8:85-2.21(e)2iv is consistent with longstanding Department policy. SCNF level of nursing care includes services that would be considered additional nursing services for NF level of nursing care. The Department will amend proposed N.J.A.C. 8:85-2.21(e)2iv upon adoption to delete reference to "acuities," because this term is more properly used in connection with Medicare Part A skilled nursing services.

N.J.A.C. 8:85-3.9 Routine patient care expenses

68. COMMENT: The proposed amendment at N.J.A.C. 8:85-3.9(b)2iii appears to be consistent with current practice and we have no objection to this change. (2)

69. COMMENT: The modifications, restructuring and inclusion of proposed N.J.A.C. 8:85-3.9(b) is extremely helpful, particularly the "month of onset" and "counting" guidance provided for in proposed N.J.A.C. 8:85-3.9(b)1iii(1) through (3). (3)

RESPONSE TO COMMENTS 68 AND 69: The Department believes the commenter for comment 68 intended to reference to N.J.A.C. 8:85-3.9(b)1iii, not N.J.A.C. 8:85-3.9(b)1iii. The Department thanks the commenters for their support of the proposed amendments.

N.J.A.C. 8:85-3.13 Moveable equipment

70. COMMENT: Regarding proposed N.J.A.C. 8:85-3.13(c), there appear to be two typographical errors. A reference to an effective date of July 1, 2000 is proposed as new language and the word "not" has been inserted in the sentence "provision for ongoing routine equipment maintenance and replacements will be included" allowance. The Summary makes no reference to a change in this area, and the word "not" is not shown in boldface. If a proposed change was intended, we request an appropriate public comment period. (1)

71. COMMENT: We have been verbally advised that the addition of the phrase "Effective with rates implemented on or after July 1, 2000," and the addition of the word "not" were in error, were included by oversight, and were not intended to be added to be part of the proposal. We request that the Department confirm this upon adoption. (2)

RESPONSE TO COMMENTS 70 AND 71: The commenters are correct. The Department did not intend to modify proposed N.J.A.C. 8:85-3.13(c) by the addition of the phrase "Effective with rates implemented on or after July 1, 2000," and the addition of the word "not." The text appears in error. The word "not" is not part of the existing rule and because it was not proposed as new text, the Department should not have included it the proposal. The Department will not adopt this text. The Department will amend proposed N.J.A.C. 8:85-3.13(c) upon adoption to delete the phrase "Effective with rates implemented on or after July 1, 2000," and the word "not."

N.J.A.C. 8:85-3.21 Appeals process

72. COMMENT: Proposed N.J.A.C. 8:85-3.21 would amend the process for submission of Medicaid rate appeals by facilities for the Medicaid reimbursement rates set by the State. The changes would extend the time for original submission of a rate appeal from 20 days to 60 days and would consolidate the submission of the appeal and supporting documentation to the initial appeal mailing. We have no objection to the proposal.

In addition, the proposal adds new language that would limit the scope of appeal at any subsequent Level I and Level II hearings to issues identified in the original appeal submission. We understand this language reflects current practice of the State and assume that the added language is being proposed to clarify the current practice. We have no objections to this clarification. (2)

RESPONSE: The Department intends the proposed amendments at N.J.A.C. 8:85-3.21 to bar from consideration at appeal Level II issues not identified as remaining outstanding and unresolved upon the conclusion of proceedings at Level I to prevent unfair surprise and to allow the Department to prepare appropriately for issues raised at Level II. Several separate programs of the Department share responsibility for administering the rate setting process. The Department has experienced situations in which a representative with expertise in the issues raised at Level I would appear at a Level II hearing only to be faced with responding to issues not raised at Level I that require the expertise of personnel in a different unit of the Department to respond. The Department has experienced situations in which issues the Department considered to be settled at Level I were raised in connection with the appeal of a separate issue at Level II. The proposed amendments would address these situations.

73. COMMENT: What rate appeals will be affected by the new appeals process? (1)

RESPONSE: The Department reviews cost studies in support of an annual rate application using the rules applicable at the time of an application for approval of an annual rate. Therefore, the Department would apply the rules in effect and operative at the time of its issuance of an annual rate approval to an appeal of that approval.

Summary of Agency-Initiated Changes:

1. The Department is making technical corrections throughout the chapter to correct grammar and spelling; to improve sentence structure; to delete descriptive text when an acronym or shorthand reference term is available; to eliminate the passive voice; to update references to the Department and its programs to reflect organizational changes within the Department; to correct addresses; to replace usages of the symbol "/" with words where "/" was used as a substitute for an available more meaningful word such as "and," "or," or "per"; and to replace cross-references to existing N.J.A.C. 10:63 with cross-references

to the corresponding citations in proposed N.J.A.C. 8:85. In addition, the Department is replacing references to the phrase "six months" with the more precise "180 days," throughout the chapter.

2. The Department will amend proposed N.J.A.C. 8:85-1.2, Definitions, upon adoption to relocate the description of care management provided at proposed N.J.A.C. 8:85-1.8(h)2i through iv to the proposed definition of "care management." The Department will delete the corresponding text at proposed N.J.A.C. 8:85-1.8(h)2i through iv.

3. The Department will amend proposed N.J.A.C. 8:85-1.2, Definitions, upon adoption to add a definition of the term "Long-Term Care Field Office" or "LTCFO," which is a term used throughout the chapter.

4. The Department will amend proposed N.J.A.C. 8:85-1.2, Definitions, upon adoption to add definitions of the terms "mental illness" and "mental retardation" by incorporating by reference the Federal descriptions of these diagnoses for preadmission screening purposes. In addition, the Department will amend upon adoption the existing definitions of the terms "special services for mental illness (MI)" and "special services for mental retardation (MR)" to delete the parenthetical shorthand references. New Jersey Administrative Code style convention regarding use and interpretation of parenthetical shorthand references could result in the incorrect assumption that the appearance of the terms "MI" or "MR" in the rules means special services for these conditions, rather than the conditions themselves. In addition, the Department is making appropriate amendments throughout the chapter upon adoption to ensure that the usages of "MI" and "MR" refer to the respective conditions, and not special services associated with the conditions.

5. The Department will amend proposed N.J.A.C. 8:85-1.2, Definitions, upon adoption to delete the existing definition of the term "Minimum data set (MDS)." The Department proposed a new definition of the term "Minimum Data Set (MDS) version 2.0 or most current version" at proposed N.J.A.C. 8:85-1.2, but the existing similar definition was not proposed for deletion. Upon adoption, the Department will amend the proposed new definition of the term "Minimum Data Set (MDS) version 2.0 or most current version" to incorporate elements of the existing definition of the term "Minimum data set (MDS)." Additionally, the Department will amend proposed N.J.A.C. 8:85-1.13(d) to replace the acronym "SRA" with "MDS" because the phrase "Standardized Resident Assessment (SRA) instrument" will be removed from the proposed new definition of the term "Minimum Data Set (MDS) version 2.0 or most current version" upon adoption because the MDS is the standardized resident assessment instrument, the SRA, that is used in New Jersey.

6. Existing references in N.J.A.C. 10:63 to PASARR stand for "preadmission screening and annual resident review." Pub. L. 104-315, enacted October 19, 1996, amended Title XIX of the Social Security Act at 42 U.S.C. §1396r by eliminating the requirement of annual Medicaid eligibility reviews for persons with mental illness and mental retardation. The proposed repeal and new rule at N.J.A.C. 8:85-1.8, and the proposed repeal of N.J.A.C. 8:85-1.11, reflect the Department's elimination of the requirement for annual Medicaid eligibility reviews for persons with mental illness and mental retardation in conformance with the Federal government's elimination of this requirement.

However, the Department did not propose to amend the definition of the term "preadmission screening and annual resident review" or "PASARR" at existing N.J.A.C. 10:63-1.2, Definitions, to delete the word "annual" from the term name, to delete the phrase "annually thereafter" from the definition, and to modify the acronym from PASARR to "PASRR." The Department will amend proposed N.J.A.C. 8:85-1.2 upon adoption to change the term "preadmission screening and annual resident review" or "PASARR" to "preadmission screening and resident review" or "PASRR." In addition, on adoption, the Department will replace the phrase "annually thereafter" in the definition at existing N.J.A.C. 10:63-1.2, proposed for recodification and readoption without change at N.J.A.C. 8:85-1.2, with the phrase "when there is a change in the individual's condition," which is consistent with the proposed new rule at N.J.A.C. 8:85-1.8 as to the operation of the PASRR process. In addition, the Department will amend proposed N.J.A.C. 8:85-1.8 and 1.13 upon adoption to replace references to "PASARR" with "PASRR."

The Department acknowledges for the benefit of the regulated community that while the Federal statute cited above no longer requires annual review, CMS appears not to have made corresponding amendments to the implementing regulations. Throughout the rules proposed for readoption and recodification, and the proposed amendments, the Department refers to and incorporates by reference the Federal government's regulations that implement the enabling legislation cited above, 42 CFR §§101 et seq., particularly 42 CFR §§483.102, which describes mental illness and mental retardation for purposes of preadmission screening, 483.120, which describes and the specialized services the state provides for persons with MI or MR, and 440.150, which describes intermediate care facility services. These particular sections do not use the term PASARR; however, other citations in 42 CFR §§101 et seq. do use this term.

To the extent Federal implementing regulations to which the Department cites or incorporates by reference refer to the requirement of annual review, the Department will adhere to the Federal statute and not require annual review.

7. The Department will amend proposed N.J.A.C. 8:85-1.2, Definitions, upon adoption to relocate the descriptions of tracks of care I, II, and

III provided at proposed N.J.A.C. 8:85-1.8(e) to the existing definitions of these three tracks provided in the definition of "track of care." The Department will amend the relocated text upon adoption to replace lengthy descriptions of terms and processes in this text with defined shorthand references for these terms and processes. The Department will delete proposed N.J.A.C. 8:85-1.8(e) and recodify the remaining subsections to reflect the deletion.

8. The Department will amend proposed N.J.A.C. 8:85-1.8 upon adoption as follows:

a. Throughout the section, the Department will replace the phrase "Medicaid eligible" with the more precise phrase "financially eligible for Medicaid." Eligibility for Medicaid reimbursement for NF services depends on both financial and clinical eligibility. The CWA determines financial eligibility but the LTCFO must conduct PAS to determine whether an individual is clinically eligible for Medicaid. As used on proposal, the Department intended "Medicaid eligible" to mean "financial eligibility," and therefore amendment is appropriate to ensure precision of meaning.

b. The Department will replace lengthy references to and descriptions of PAS, PASRR, DMHS, DDD, NF, MI, MR, with their acronyms, inasmuch as these are defined terms.

c. Throughout the section, the Department will correct inaccurate references to the Appendices, to form names, and to web addresses at which forms are available for download.

d. Throughout the section, the Department will more precisely identify the forms that the Department, applicants and referents are to use in the Medicaid authorization process by referencing these documents in the Appendices.

(i) Proposed N.J.A.C. 8:85-1.8(f)1i references the HSDP but does not provide a cross reference to the form of the HSDP at proposed Appendix L. Upon adoption the Department will delete the description of the HSDP, and provide a cross reference to Appendix L, which was provided in the proposed N.J.A.C. 8:85, that is recodified upon adoption as N.J.A.C. 8:85-1.8(e)1i(1).

(ii) Proposed N.J.A.C. 8:85-1.8(f)1i references a "signed approval/denial letter" but does not provide a cross reference to the form of the approval letter that was provided at proposed Appendix M. Upon adoption the Department will add a cross reference to Appendix M that is recodified upon adoption as N.J.A.C. 8:85-1.8(e)1i(1). This Agency-Initiated Change is consistent with the Department's intent to clearly articulate the notice requirements addressed in Agency-Initiated Change 8i that would be imposed on the Department for the benefit of the regulated public.

(iii) Proposed N.J.A.C. 8:85-1.8(f)1i references a "signed approval/denial letter" but does not provide a cross reference to the form of the denial letter which was provided at proposed Appendix N. Upon adoption the Department will add a cross reference to Appendix N that is recodified upon adoption as N.J.A.C. 8:85-1.8(e)1i(2). This Agency-Initiated Change is consistent with the Department's intent to clearly articulate the notice requirements addressed in Agency-Initiated Change 8i that would be imposed on the Department for the benefit of the regulated public.

(iv) In accordance with 42 CFR §483.128, the Department must provide written notice to an individual suspected of having MI or MR, or his or her legal representative, that he or she is being referred to the State mental health or mental retardation authority for a Level II screen. The Department will add upon adoption as new Appendices R and S, form letters referred to that the Department uses, depending on the situation with respect to individuals with MI or with MR, in notifying applicants that the PASRR is required for an eligibility determination. This Agency-Initiated Change will provide a cross reference consistent with the Department's intent to clearly articulate the notice requirements addressed in Agency-Initiated Change 8k that would be imposed on the Department for the benefit of the regulated public.

(v) In accordance with Agency-Initiated Change 8d, the Department will identify the Hospital Preadmission Screening Referral Form in the section. Also, the Department will add upon adoption, as new Appendix

T, the Hospital Preadmission Screening Referral Form described in the section, as a cross reference to the form a referent should use.

e. Throughout the section, the Department will correct usages of the passive voice and other ambiguities arising from sentence structure to more precisely identify which of the individuals or entities involved in an application for Medicaid benefits (such as the LTCFO, the CWA, the referent, the hospital, the NF, the applicant, the applicant's legal representative, the DMHS, or the DDD) is responsible for each step in the process.

f. At proposed N.J.A.C. 8:85-1.8(a), the Department will relocate the phrase "regardless of payment source" to emphasize that this phrase modifies only the phrase "an individual with MI or MR."

g. At proposed N.J.A.C. 8:85-1.8(a)2, the Department will add the phrase "for less than one year" with reference to an individual admitted to a psychiatric unit for treatment, to make the requirement of PASRR for readmission to a NF from a psychiatric unit consistent with the corresponding requirement at N.J.A.C. 10:52-1.11(d)5.

h. At proposed N.J.A.C. 8:85-1.8(g)3, the Department will add the phrase "outside of" to correct a typographical error that is in existing N.J.A.C. 10:63-1.11(i)3 and that was not corrected by the Department on proposal. On adoption, the revised text will read: "The Department will review the records provided to determine the need for long-term care services and to determine the appropriateness of placing the beneficiary in a NF outside of New Jersey."

i. On adoption the Department will add new language to articulate the Department's procedures that are currently and would continue to be followed by a referent hospital for individuals requiring PAS and who also have been diagnosed with MI and/or MR. Proposed N.J.A.C. 8:85-1.8(f)1i would require professional staff designated by the Department to advise a referent and family/authorized representative that an evaluation for specialized MI or MR services is required. The form of such advice is not set forth in proposed N.J.A.C. 8:85-1.8(f)1i. In addition, the term "family" does not clearly articulate which member of a family

would be legally entitled to receive notifications on behalf of an individual. Therefore, on adoption, the Department will add language at N.J.A.C. 8:85-1.8(e)1i(3) which requires the form of notice to be sent by the Department to individuals and, as appropriate their legal representative, in the form provided at Appendix R for individuals with MI and Appendix S for individuals with MR, as discussed in Agency-Initiated Change 8d(iv). Inasmuch as the requirement to provide such notice is imposed on professional staff designated by the Department, the requirement does not increase the burden on referent hospitals or potential beneficiaries or their legal representatives. Requiring notice to be sent by professional staff designated by the Department to individuals and their legal representative increases the protection offered to them by assuring that individuals and their legal representatives receive written verification from the Department that PASRR is required.

Proposed N.J.A.C. 8:85-1.8(f)1i would require professional staff designated by the Department to send approval/denial letters to a referent and to an individual or his or her family. Proposed N.J.A.C. 8:85-1.8(f)1i does not specify the form that such approval letter shall take, but a form of approval letter is contained at Appendix M. The Department intends that individuals with MI and/or MR, who do not require specialized services for MI and/or MR, but who otherwise are determined through PAS to be clinically eligible for NF services to receive the form of letter set forth in the proposal at Appendix M. On adoption, the Department will codify this intent at N.J.A.C. 8:85-1.8(e)1i(4), and as discussed in Agency-Initiated Change 8d(ii).

Proposed N.J.A.C. 8:85-1.8(f)1i would also require professional staff designated by the Department to send a denial letter to a referent and to an individual or his or her family. Proposed N.J.A.C. 8:85-1.8(d)2i(1)iv would provide that, in the event an individual diagnosed with MI and/or MR is determined to require specialized services, NF placement is inappropriate. Proposed N.J.A.C. 8:85-1.8(f)1i does not specify the form that such denial letter shall take but a form of denial letter is contained at Appendix N. The Department intends for individuals with MI and/or MR, who require specialized services for MI and/or MR, to receive a denial letter from the Department in the form set forth in the proposal at Appendix N. On adoption, the Department will codify this intent at N.J.A.C. 8:85-1.8(e)1i(5), and as discussed in Agency-Initiated Change 8d(iii).

j. On adoption, the Department will add new language at N.J.A.C. 8:85-1.8(e)2, which articulates the Department's procedures to be followed by a referent NF that is referring an individual, residing in the NF, for PAS. Proposed N.J.A.C. 8:85-1.8(d) would require professional staff designated by the Department to review the medical, nursing and social information obtained about an individual at the time of assessment. Proposed N.J.A.C. 8:85-1.8(f)1i would require professional staff designated by the Department to complete a standardized assessment of an individual after the individual is identified by a referent pursuant to proposed N.J.A.C. 8:85-1.8(f)1. Pursuant to proposed N.J.A.C. 8:85-1.8, referents may be a hospital, a NF or another entity or person, if the individual being referred by such entity or person for NF placement resides in the community. On adoption, the Department will add new language at N.J.A.C. 8:85-1.8(e)2i, which articulates the Department's intent that when a NF refers an individual for PAS, PAS will be conducted in accordance with the procedures set forth at proposed N.J.A.C. 8:85-1.8(d) and by completing the standardized assessment. The new language at N.J.A.C. 8:85-1.8(e)2i merely restates the requirements for PAS that were articulated by proposed N.J.A.C. 8:85-1.8(d) and (f)1i.

k. On adoption, the Department will add new language at N.J.A.C. 8:85-1.8(e)3 which articulates the Department's procedures to be followed by a referent when an individual resides in the community. Proposed N.J.A.C. 8:85-1.8(f)3 would require that individuals residing in the community shall be referred to the LTCFO for PAS. However, proposed N.J.A.C. 8:85-1.8(f)3 does not expressly provide the form that such referral will take. Appendix H, Certification of Need for Patient Care in Facility other than Public or Private General Hospital, also known as the PA-4, was published in proposed N.J.A.C. 8:85. The Department intended the PA-4 to be used by community referents referring an individual who may be clinically eligible for Medicaid NF services who is also residing in the community at the time of referral. Therefore, the Department will provide additional language on adoption at N.J.A.C. 8:85-1.8(e)3 to clearly articulate that community referents shall use the PA-4 to refer individuals residing in the community for PAS.

Proposed N.J.A.C. 8:85-1.8(f)3i would have required that an individual receive notification from the LTCFO of approval or denial of NF placement. On adoption, the Department will add new

language at N.J.A.C. 8:85-1.8(e)3i(1) to provide that such notice from the Department will be in the form of proposed Appendix M, for individuals approved for NF placement and proposed Appendix N, for individuals who are denied clinical eligibility for NF placement by the Department, and as discussed in Agency-Initiated Changes 8d(ii) and (iii). The requirement of the Department to use Appendices M and N was not contained in proposed N.J.A.C. 8:85-1.8(f)3i. The Agency-Initiated change at N.J.A.C. 8:85-1.8(e)3i(1) will also provide that approval or denial notices, as applicable, will be mailed, not sent to the individual applicant. The Agency-initiated change at N.J.A.C. 8:85-1.8(e)3i(1) will also provide that approval or denial notices, as applicable, will be mailed to an individual's legal representative not "family," for the reasons articulated above in Agency-Initiated Change 8i. The intent for these Agency-Initiated changes is to more clearly articulate the notice requirements imposed on the Department for the benefit of the regulated public that should have been published in the proposal.

Proposed N.J.A.C. 8:85-1.8(f)3ii and iii would have provided the requirements to be used by a referent of an individual residing in the community, requiring PAS, and who also has been diagnosed with MI and/or MR. For individuals with either diagnosis, MI or MR, the referring entity would have been required under proposed N.J.A.C. 8:85-1.8(f) to identify an individual who was potentially clinically eligible for Medicaid funded NF services. As set forth above, referral of an individual, who may be clinically eligible for Medicaid NF services and who resides in the community, would be accomplished by the referent completing the PA-4. Additionally, for individuals diagnosed with MI and/or MR, proposed N.J.A.C. 8:85-1.8(f)1i would have required professional staff designated by the Department to verbally notify the MI and/or MR diagnosed individual or their family of the results of PAS and that further evaluation for specialized MI or MR services may be required. The Agency-initiated changes that will be made upon adoption at N.J.A.C. 8:85-1.8(e)3ii and iii will more clearly articulate the Department's intended requirement that such verbal notification must be given by the Department to MI or MR diagnosed individuals seeking a clinical eligibility determination for Medicaid NF services and, as applicable, their legal representatives if such individual is being referred from a community setting. In addition, proposed N.J.A.C. 8:85-1.8(f)3ii and iii would have required the completion of Appendix I also known as the Psychiatric Evaluation. The responsibilities of the various parties required to complete Appendix I were not clearly stated by the Department in proposed N.J.A.C. 8:85-1.8(f)3ii or iii, although such responsibilities are contained in the instructions for completing the Psychiatric

Evaluation. Therefore, on adoption, the Department will adopt Agency-initiated changes which clearly articulate the procedures the Department, referents and individuals and their legal representatives must follow in the event an individual diagnosed with MI and/or MR is referred for a clinical eligibility determination for Medicaid services provided in a NF. Proposed N.J.A.C. 8:85-1.8-1.8(f)1i would have required the Department to advise that an evaluation for specialized services is required. The Agency-initiated changes at N.J.A.C. 8:85-1.8-1.8(e)3ii(2) and iii(2) would articulate that the Department would advise MI and MR individuals, respectively, pursuant to the form of notice provided at new Appendices R and S, respectively, and as discussed in Agency-Initiated Change 8d(iv).

In addition, proposed N.J.A.C. 8:85-1.8(f)3ii would have required the completion of a Psychiatric Evaluation form for individuals diagnosed with MI who require PASRR. The requirements of responsible parties for completing the Psychiatric Evaluation are contained therein but are not clearly articulated by proposed N.J.A.C. 8:85-1.8(f)3ii. Therefore, on adoption, the Department will make an Agency-initiated change at N.J.A.C. 8:85-1.8(e)3ii(2) wherein the professional staff designated by the Department will provide an individual or his or her legal representative with Appendix R.

l. As set forth above, under Agency-Initiated Change 6, Pub.L. 104-315 eliminated the requirement of annual Medicaid eligibility reviews for persons with MI or MR residing in a NF. Proposed N.J.A.C. 8:85-1.8(i) would have required NF's to make a clinical judgment as to whether a PASRR review by DMHS or DDD is needed if a NF beneficiary diagnosed with MI and/or MR experiences a significant change in condition. However, proposed N.J.A.C. 8:85-1.8(i) does not articulate what, if anything, the NF must do if it decides that PASRR is required for a NF resident who has MI or MR and who is experiencing a significant change in condition. Pursuant to 42 CFR 483.128, a state mental health or mental retardation authority must conduct a review and determination for MI and/or MR specialized serviced, therefore, the Department will adopt an Agency-initiated change at N.J.A.C. 8:85-1.8(h). This change would require the NF to notify the State authority, which in New Jersey is either DMAHS for MI individuals or DDD for MR individuals, so that the Federally mandated evaluation may be completed. Inasmuch as the procedures for individuals with MI for continued NF stay at existing N.J.A.C. 10:63-1.11(e) require NF's to forward,

annually, a completed Psychiatric Evaluation form to DMAHS, the reporting requirement proposed for adoption at N.J.A.C. 8:85-1.8(h) is no greater on the affected NF than the reporting requirement under existing rules at N.J.A.C. 10:63-1.11(e).

m. Proposed N.J.A.C. 8:85-1.8(d)2i references the Psychiatric Evaluation form, which was provided at proposed Appendix I, and identifies the individuals who would complete the form. However, proposed N.J.A.C. 8:85-1.8(d)2i does not identify the sections of the form that each individual would complete. In an effort to articulate how the Psychiatric Evaluation form would be completed, the Department will add new language at N.J.A.C. 8:85-1.8(d)2i upon adoption to identify which individual would be responsible for completing certain sections of the Psychiatric Evaluation form in accordance with the form; the Psychiatric Evaluation form identifies who would complete a particular section of the form.

n. Proposed N.J.A.C. 8:85-1.8(d)2i identifies a certified nurse practitioner, who is "certified in the advance practice of psychiatric/mental health", and a clinical nurse specialist, who is "certified in the advance practice of psychiatric/mental health", in a list of professionals permitted to complete a Psychiatric Evaluation form, but does not provide a cross reference to the "Advance Practice Nurse Certification Act" (N.J.S.A. 45:11-45 et seq.) which provides the requirements for certification as an advance practice nurse. Upon adoption, the Department will provide a cross reference to the Act, specifically N.J.S.A. 45:11-45 et seq., since pursuant to N.J.S.A. 45:11-46a(1), "[n]o person shall practice as an advance practice nurse or present, call or represent himself as an advanced practice nurse unless certified." Additionally, pursuant to N.J.S.A. 45:11-46c, "whenever the titles or designations 'nurse practitioner,' 'clinical nurse specialist' or 'nurse practitioner/clinical nurse specialist' occur or any reference is made thereto in any law, contract or document, the same shall be deemed to mean or refer to the title or designation 'advanced practice nurse." The new language will be added to N.J.A.C. 8:85-1.8(d)2i and N.J.A.C. 8:85-1.8(e)3ii(3).

o. Proposed N.J.A.C. 8:85-1.8(f)1, which will be recodified upon adoption as N.J.A.C. 8:85-1.8(e)1, is ambiguous because the initial references to the "referent" only imply that

the referent is a hospital. The context of the paragraph clearly indicates that it only pertains to hospitals, but the referent is not identified as a hospital in the section until proposed N.J.A.C. 8:85-1.8(f)1i(1). Upon adoption, the Department will add new language to identify the referent in this section as a hospital at the beginning of the section in an effort to eliminate any confusion.

9. The Department will amend proposed N.J.A.C. 8:85-3.21, Appeals process, upon adoption to correct mailing addresses contained therein.

10. The Department inaccurately represented the proposed disposition of some of the existing appendices at N.J.A.C. 10:63. Noted in the header of this notice of adoption, and following, is an accurate description of the disposition of these appendices.

On proposal, the Department accurately represented the proposed repeal of the existing forms provided at Appendices A through H, J, L through N, P and Q, and accurately represented the new forms proposed to replace these appendices. On proposal, the Department accurately represented its proposed repeal without replacement of Appendix O.

On proposal, the Department accurately represented its intention to repeal the existing form at Appendix I and to replace it with an updated version of the form. However, the most recently updated version of the new form, which reflects a different mailing address, was not published in the proposal. Therefore, the Department, as proposed, will repeal existing Appendix I that appears at N.J.A.C. 10:63, but upon adoption will not adopt the proposed version of new Appendix I, and will adopt an updated version of Appendix I.

Agency Note: Contrary to the Department's intention, the last two sentences of existing N.J.A.C. 10:63-2.1(a)1, to be recodified upon adoption as N.J.A.C. 8:85-2.1(a)1, should have been proposed for deletion but were inadvertently published as unchanged language in the proposal. These two sentences are as follows: "Dependency in activities of daily living (ADL) may have a high degree of individual variability. Each separate ADL may be classified as either independent, requiring some assistance, or totally dependent." Since the deletion would be substantive and would require notice and opportunity to comment, the Department will propose these sentences for deletion in a subsequent rulemaking proposal. The proposed amendment would delete categorization of varying degrees of dependency with respect to ADLs, and would emphasize that a beneficiary's eligibility is conditioned upon the establishment of dependency in "several" ADLs. The Department's intended policy is that "independence" would not qualify as an ADL dependency sufficient

to trigger eligibility for nursing facility services pursuant to proposed N.J.A.C. 8:85-2.1.

Federal Standards Statement

The readopted rules and the adopted recodification, new rules, amendments and repeals do not impose requirements in excess of Federal requirements at 42 U.S.C. §1396a(a)(13)(A) and 42 U.S.C. §1396r. N.J.A.C. 8:85-1.8 incorporates by reference, as amended and supplemented, the pre-admission screening and resident review criteria at 42 CFR §483.102 and 120. Subject to the discussion regarding annual conduct of PASRR in item 6 in the Summary of Agency-Initiated Changes above, N.J.A.C. 8:85 meets, but does not exceed, these Federal requirements. Therefore, a Federal standards analysis is not required.

Nursing facility reimbursement is governed by Federal law at 42 U.S.C. §1396a(a)(13)(A), which requires that the methodologies underlying the establishment of the rates, and justification for the proposed rates, be published so as to allow providers, beneficiaries, their representatives, and other concerned State residents the opportunity to comment. The notice of proposal and this notice of adoption are intended to satisfy the statutory requirement at 42 U.S.C. §1396a(a)(13)(A).

Except as described above, no Federal standards are applicable to the subject of the readopted rules and the adopted recodification, new rules, amendments and repeals at N.J.A.C. 8:85

Full text of the readopted rules can be found in the New Jersey Administrative Code at N.J.A.C. 10:63, pending recodification as N.J.A.C. 8:85 through the January 17, 2006 Code update.

Full text of the adopted amendments, new rules, and recodification follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

(**Agency Note:** Proposed N.J.A.C. 8:85 Appendix I is not being adopted by the Department; instead, new Appendix I revised from that proposal is adopted, and appears below as the adopted text of that Appendix. The deletion of proposed Appendix I does not appear below.)

CHAPTER *[63]* ***85***

LONG-TERM CARE SERVICES

8:85-1.1 Scope

This chapter addresses the provision of quality, cost-prudent health care services available to New Jersey Medicaid eligible children and adults in a nursing facility (NF) and addresses the provision of and reimbursement for services required to meet the individual's medical, nursing, rehabilitative and psychosocial needs to attain and maintain the highest practicable mental and physical functional status. The following subchapters specifically address nursing facility services. However, the Fiscal Agent Billing Supplement continues to apply to all government psychiatric hospitals, inpatient psychiatric services and programs in long term care facilities. These other types of facilities are addressed for regulatory and administrative matters in the appropriate chapters elsewhere in Title 10 of the New Jersey Administrative Code.

8:85-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

["Beds" or "licensed beds" means, with reference to a facility, the total number of beds on the facility's certificate/license.] ***"Bed" or "licensed bed" means "bed" or "licensed bed" as those terms are defined at N.J.A.C. 8:39-1.2.***

"Beneficiary" means a qualified applicant receiving benefits under the Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 et seq.

"Care management" means a process by which professional staff designated by the Department *[of Health and Senior Services]* monitor the provision of *[nursing facility]* ***NF*** care to *[assure]* ***:***

1. Assure that services are rendered as recommended by the HSDP and in accordance with the NF's evaluation of the individual's health service needs;

2. Assure the delivery of timely and appropriate provider responses to changes in care needs *[and delivery of coordinated services]* ***;***

3. Provide, direct or secure needed consultations with Medicaid professional or NF staff so that services are delivered in a coordinated, effective, and cost-prudent manner; and

4. Facilitate discharge planning and promote appropriate placement to alternate care settings.*

"County welfare agency (CWA)" means that agency of county government with the responsibility to determine income eligibility for public assistance

programs including Aid to Families with Dependent Children, the Food Stamp program, and Medicaid. The CWA may be identified as the Board of Social Services, the Welfare Board, the Division of Welfare, or the Division of Social Services.

"Department of Health and Senior Services" (Department or DHSS) means the New Jersey State Department of Health and Senior Services.

"Department of Human Services" (DHS) means the New Jersey State Department of Human Services.

"Division of Developmental Disabilities" (DDD) means the New Jersey State Department of Human Services, Division of Developmental Disabilities.

"Division of Medical Assistance and Health Services" (DMAHS) means the New Jersey State Department of Human Services, Division of Medical Assistance and Health Services.

"Division of Mental Health Services" (DMHS) means the New Jersey State Department of Human Services, Division of Mental Health Services.

"Health Services Delivery Plan (HSDP)" means a plan of care prepared by professional staff designated by the Department during the Pre-Admission Screening (PAS) assessment process which reflects the individual's current or potential health problems and required care needs.

"Long-Term Care Field Office" or "LTCFO" means the regional office of the Office of Community Choice Options of the Division of Aging and Community Services of the Senior Services Branch of the Department.

"Material fact" means any reported costs, statistics, data or supporting documentation submitted to the Medicaid program for the purpose of receiving any benefit, regardless of whether any benefit is ultimately received.

"Mental illness" or "MI" means mental illness as that term is defined at 42 CFR §483.102, incorporated herein by reference, as amended and supplemented.

"Mental retardation" or "MR" means mental retardation as that term is defined at 42 CFR §483.102, incorporated herein by reference, as amended and supplemented.

*["Minimum data set (MDS)" means a minimum set of screening and assessment elements, including common definitions and coding categories, needed to comprehensively assess an individual nursing facility resident. The items in the MDS standardize communication about resident problems and

conditions within facilities, between facilities, and between facilities and outside agencies.]*

"Minimum Data Set *[(MDS) version 2.0 or most current version" of the Resident Assessment Instrument (RAI)]* ***" or "MDS"*** means the *[Standardized Resident Assessment (SRA) instrument]* ***MDS version 2.0, incorporated herein by reference, as amended and supplemented a core set of screening, clinical and functional status elements, including common definitions and coding categories that forms the foundation of the comprehensive assessment*** required to be completed ***by a NF-registered professional nurse*** on all residents in Medicare***-*** and/or Medicaid***-***certified long***-***term care facilities on or after June 22, 1998. The MDS *[assessment]* identifies *[the]* ***an*** individual NF resident's nursing and care needs.

"Nursing facility (NF)" means an institution (or distinct part of an institution) certified by the New Jersey State Department of Health and Senior Services for participation in Title XIX Medicaid and primarily engaged in providing health-related care and services on a 24-hour basis to Medicaid beneficiaries (children and adults) who, due to medical disorders, developmental disabilities and/or related cognitive impairments, exhibit the need for medical, nursing, rehabilitative, and psychosocial management above the level of room and board. However, the nursing facility is not primarily for care and treatment of mental diseases which require continuous 24-hour supervision by qualified mental health professionals or the provision of parenting needs related to growth and development.

"Ombudsman" means the Office of the Ombudsman for the Institutionalized Elderly.

"Pre-admission screening (PAS)" means that process by which all Medicaid eligible beneficiaries seeking admission to a Medicaid certified NF and individuals who may become Medicaid eligible within six months following admission to a Medicaid certified NF receive a comprehensive needs assessment by professional staff designated by the Department to determine their long-term care needs and the most appropriate setting for those needs to be met, pursuant to N.J.S.A. 30:4D-17.10. (P.L. 1988, c.97).

"Pre-admission screening and *[annual]* resident review *[(PASARR)]* ***or "PASRR"*** means that process by which *[all]* ***an*** individual*[s]* with *[mental illness (]* **MI** *[)]* or *[mental retardation (]* **MR** *[) are]* ***is*** screened prior to admission to a NF and *[annually thereafter in order]* ***when there is a significant change in the individual's condition*** to determine the individual's appropriateness for NF services, and whether the individual requires specialized services for *[his or her condition]* ***MI provided by the DMHS and/or MR provided by the DDD, and therefore is ineligible for NF services***.

"Prior authorization" means approval granted by the Department through the appropriate Long-Term Care Field Office (LTCFO) for payment for NF services rendered to a Medicaid beneficiary, in accordance with this chapter.

"Professional staff designated by the Department" means a registered nurse or professional social worker who performs health needs assessments and counseling on alternative options and care management as required by this chapter. Professional social workers employed by the State or a political subdivision thereof are not required to be licensed or certified.

"Resident" means a Medicaid eligible or potentially eligible beneficiary residing in an NF.

"Social services" means those services provided to meet the emotional and social needs of the Medicaid beneficiary and significant other or guardian at the time of admission, during treatment and care in the facility, and at the time of discharge.

"Special care nursing facility (SCNF)" means a NF or separate and distinct unit within a Medicaid certified conventional NF which has been approved by the Department to provide care to New Jersey Medicaid beneficiaries who require specialized health care services beyond the scope of conventional nursing facility services as defined in N.J.A.C. 8:85-2, Nursing Facility Services.

"Specialized services for *[mental illness (]* **MI** *[)]*" mean those services offered, in accordance with 42 CFR ***§***483.120, when an individual is experiencing an acute episode of serious *[mental illness]* ***MI*** and psychiatric hospitalization is recommended, based on a *[Psychiatric Evaluation]* ***psychiatric evaluation***.

1. Specialized *[Services]* ***services for MI*** entail implementation of a continuous, aggressive, and individualized treatment plan by an interdisciplinary team of qualified and trained mental health personnel.

2. During a period of 24-hour supervision *[for the]* ***of an*** individual ***with MI***, specific therapies and activities are prescribed, with the following objectives: *[to]*

i. **To*** diagnose and reduce behavioral symptoms; *[to]*

ii. **To*** improve independent functioning; and *[as]*

iii. **As*** early as possible, to permit functioning at a level where less than specialized services are appropriate.

3. Specialized services ***for MI*** go beyond the range of services *[which]* ***that*** a NF is required to provide.

"Specialized services for *[mental retardation (]* MR *[)]* " mean those services offered, in accordance with 42 CFR ***§*** 483.120, when an individual is determined to have skill deficits or other specialized training needs that necessitate the availability of trained MR personnel, 24 hours per day, to teach the individual functional skills.

1. Specialized services ***for MR*** are those services needed to address such skill deficits or specialized training needs.

2. Specialized services ***for MR*** may be provided in an intermediate care facility for the mentally retarded ***or*** *[(]*ICF/MR*[)]* ***as defined at 42 CFR §440.150*** or in a community-based setting *[which]* ***that*** meets ICF/MR standards.

3. Specialized services ***for MR*** go beyond the range of services *[which]* ***that*** a NF is required to provide.

"Track of care" means the designation of the setting and scope of Medicaid services ***as*** determined by *[the PAS process conducted by the]* professional staff designated by the Department following *[assessment of the Medicaid eligible or potentially eligible Medicaid beneficiary]* ***PAS of an applicant for Medicaid clinical eligibility for NF placement or services***, as follows:

1. "Track I" means long-term NF care ***and shall be designated for individuals with respect to whom long-term placement is required because clinical prognosis is poor, and as to whom PAS results in a determination that short-term stays are neither realistic nor predictable and that the individual is eligible for NF level of nursing care in accordance with N.J.A.C. 8:85-2.1***.

   i. A Track I designation shall not preclude the possibility of future discharge. The professional staff designated by the Department will monitor those individuals with discharge potential, reassess the individual, and update the HSDP for a change in the track of care if appropriate.

2. "Track II" means short-term NF care ***and shall be designated for individuals as to whom PAS results in a determination that the individual requires comprehensive and coordinated NF services, in accordance with N.J.A.C. 8:85-2.1, provided in a therapeutic setting that assures family counseling and teaching in preparation for discharge to the community**

setting and to achieve at least one of the objectives listed at 2i through iii below; provided that individuals designated for Track II shall also be assigned to short-term NF stays, in spite of technically complex care needs and guarded prognosis, particularly in cases in which the individual is motivated towards NF alternatives and/or in which caregivers, through case management intervention, may obtain services that make return to the community a viable option.

i. To stabilize medical conditions;

ii. To promote rehabilitation; or

iii. To restore maximum functioning levels.*

3. "Track III" means long-term care services in *[a]* ***the*** community *[setting.]* ***and shall be designated for individuals as to whom PAS results in a determination of Medicaid clinical eligibility for NF care in accordance with N.J.A.C. 8:85-2.1, but who can be appropriately cared for in the community with supportive health care services. These individuals may be eligible for Medicaid State Plan services or Home and Community-Based Services Waiver Programs.***

8:85-1.3 Program participation

(a) NF shall comply with the following requirements in order to be eligible to participate in the New Jersey Medicaid program. An in-State NF shall:

1. Be licensed by the *[New Jersey]* Department *[of Health and Senior Services]* in accordance with N.J.A.C. 8:39;

2. Be certified by the *[New Jersey]* Department *[of Health and Senior Services]*, and in the case of both Medicare and Medicaid, by the Centers for Medicare & Medicaid Services (CMS), which assures that the NF meets the Federal requirements for participation in Medicaid and Medicare;

3. Be approved for participation as a NF provider by the New Jersey Medicaid program. This includes the filing of a New Jersey Medicaid Provider Application PE-1 that establishes eligibility to receive direct payment for services to recipients under the New Jersey Medicaid program (see Appendix A as

posted at www.state.nj.us/health/ltc/ formspub.htm), the signing of a Participation Agreement PE-3 which is the participation agreement between the nursing facility and DHSS which stipulates that a NF shall provide all NF services required by N.J.A.C. 8:85 (see Appendix B as posted at www.state.nj.us/health/ltc/formspub .htm), and submittal of the CMS-1513 that is required to be completed before the State agency or Federal agency will enter into a contract for reimbursement of medical services, Ownership and Control Interest Disclosure Statement (see Appendix C as posted at www.state.nj.us/ health/ltc/formspub.htm). The agreement for participation in the New Jersey Medicaid program stipulates that a NF shall provide all NF services required by N.J.A.C. 8:85. Continued participation as a New Jersey Medicaid provider will be subject to recertification by the Department and compliance with all Federal and State laws, rules and regulations. Upon recertification by the Department, each NF will receive notification from the Department's Office of Provider Enrollment, informing the facility that their provider agreement is being continued.

4. File ***with the Department*** a completed Cost *[Report]* ***Study*** for Nursing Facility form *[Version 5.0, an annual report which must be filed by every NF seeking Medicaid payment that establishes a per diem rate based upon information provided by the NF (see]* ***in the form provided at*** Appendix D *[) with the Department]* ***, incorporated herein by reference***. After the initial cost *[report]* ***study*** is filed, the provider shall file a Cost *[Report]* ***Study*** for Nursing Facility form *[Version 5.0]* annually.

5. (No change.)

6. Accept as payment in full the Medicaid program's reimbursement for all covered services delivered during that period when, by mutual agreement between Medicaid and the facility, the beneficiary is under the provider's care, in accordance with 42 CFR § 447.15 and N.J.S.A. 30:4D-6(c); and

7. Except as provided in (a)7i below, by December 1, 1997, be certified by Medicare as a provider of skilled nursing services for no less than seven percent of the facility's total licensed long-term care beds.

i. (No change.)

ii. Upon receipt of the application, the Department *[of Health and Senior Services]* shall determine whether the facility shall be recommended for Medicare certification in accordance with 42 *[C.F.R.]* ***CFR Part*** 483. If the facility cannot be certified for Medicare participation, the Department shall provide the facility with the reasons for the certification denial in writing.

8:85-1.4 (No change in text.)

8:85-1.5 Medicaid occupancy level

(a) The NF Medicaid occupancy level shall be calculated by adding the total days for Medicaid beneficiaries residing in the NF during the month, dividing this sum by the number of days in the month to determine the average daily census, and dividing this amount by the total number of licensed long-term beds.

1. *[A Special Care Nursing Facility (SCNF) which]* ***An SCNF that*** is an identifiable unit within a conventional NF shall calculate its occupancy level separate and apart from the occupancy level of the conventional NF beds using the same formula as cited in (a) above.

2.-3. (No change.)

8:85-1.6 Termination of a Medicaid NF provider agreement

(a) The Department shall terminate a NF's Medicaid provider agreement if:

1. The Long***-***Term Care Licensing and Certification Program of the Department or the Centers for Medicare & Medicaid Services (CMS) determines that the NF is no longer certified to provide NF services. In that case:

i. The Medicaid provider agreement shall be terminated 23 days from the survey date if the Long Term Care Licensing and Certification Program of the Department or the CMS finds that deficiencies pose immediate jeopardy to residents' health and safety.

ii. If the deficiencies do not pose immediate jeopardy to the resident's health and safety, the Medicaid provider

agreement shall be terminated *[ninety]* ***180*** days from the survey date.

iii. The termination of provider agreement shall be rescinded if, prior to the effective date of termination, the Long Term Care Licensing and Certification Program of the Department or the CMS determines that the deficiencies have been satisfactorily corrected and the NF is certified to provide NF services; and

2. The Department determines that other good cause for such termination exists as cited at N.J.A.C. 10:49-11.1 or as a result of a pattern of aberrancies reported in a clinical audit as defined at N.J.A.C. 8:85-1.12.

8:85-1.7 Administrative appeal of denial, termination or non-renewal of NF certification or Medicaid Provider Agreement

(a) Any NF whose certification or Medicaid Provider Agreement is denied, terminated or not renewed shall have the opportunity to request a full evidentiary hearing before an administrative law judge, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

1. In order to obtain a hearing, the NF shall submit, within 20 days from the date of the letter proposing termination, a written request to the Division of Long Term Care Systems, Office of Program Compliance, PO Box 367, Trenton, New Jersey 08625-0367.

2.-4. (No change.)

i.-iii. (No change.)

(b) A (S)NF whose certification or Medicare/Medicaid provider agreement is denied, terminated or not renewed by CMS, may request a hearing pursuant to 42 CFR 498.40 by submitting a written request to the Centers for Medicare & Medicaid Services, Division of Health Standards and Quality, Attn: Coordinator Hearing and Appeals, Federal Building Room 3821, 26 Federal Plaza, New York, New York 10278.

1. (No change.)

8:85-1.8 Pre-Admission Screening (PAS), admission, and authorization

(a) Pursuant to N.J.S.A. 30:4D-17.10, a Medicaid***-***participating NF shall not admit *[any]* ***an*** individual who is ***financially eligible for**** Medicaid *[eligible]* or who may become ***financially eligible for**** Medicaid *[eligible]* within 180 days of admission to the *[facility]* ***NF****, or, ***regardless of payment source****, an individual with *[mental illness (]* MI *[)]* or *[mental retardation (]* MR *[) who meets the Pre-Admission Screening and Resident Review (PASARR) Criteria as defined at 42 C.F.R. §483.102 as amended and supplemented regardless of payment source]*, unless that individual has been prescreened by professional staff designated by the Department and determined appropriate for NF placement.

1. *[A]* ***An individual who is financially and clinically eligible for**** Medicaid *[eligible individual]* residing in a Medicaid****-***participating NF who is transferred to an acute care hospital shall not *[require preadmission screening]* ***be subject to PAS**** prior to returning to the same or another NF.

2. *[A]* ***If an individual who is financially and clinically eligible for**** Medicaid *[eligible individual]* identified as having MI residing in a Medicaid****-***participating NF *[who]* is admitted to a psychiatric unit for treatment ***for less than one year, the individual**** shall not be subject to *[PASARR requirements]* ***PASRR**** prior to returning to the NF.

3. *[In cases of transfer of]* ***When**** a NF resident with MI or MR ***is transferred**** to another NF, the admitting NF shall be responsible for ensuring that *[copies]* ***a copy**** of the resident's *[most recent PASARR resident assessment reports]* ***current PASRR determination****, *[SRA]* ***MDS (see N.J.A.C. 8:39-11.2(e)),**** and *[current]* HSDP ***(Appendix L, incorporated herein by reference)**** accompany the transferring resident.

(b) *[Payment will not be made by the]* ***The**** New Jersey Medicaid program ***shall not pay**** for NF services provided to *[private paying]* ***a**** resident*[s]* ***paying from private funds**** who *[have]* ***has**** applied for Medicaid benefits unless *[they have been authorized]* ***professional staff designated by the Department has determined that the resident is clinically eligible**** to receive NF services through *[preadmission screening]* ***PAS****.

1. *[In the event that]* ***If**** a NF *[admits a]* ***has admitted an individual who is financially eligible for**** Medicaid *[eligible beneficiary]* or *[an individual]* who may become ***financially eligible for**** Medicaid *[eligible]* within 180 days of admission without *[preadmission screening]* ***the professional staff designated by the Department first**

determining, through PAS, that the individual is clinically eligible for NF services*, the effective date of the initial authorization will be the date *[of]* the *[assessment]* ***PAS is completed***. *[Facilities]* ***The New Jersey Medicaid program shall not reimburse NFs*** admitting such individuals without *[preadmission screening shall not be reimbursed by the New Jersey Medicaid program]* ***PAS*** for any care rendered before *[the assessment]* ***PAS***.

(c) *[Upon]* ***Within two working days of a NF's*** admission of *[a]* ***an individual who is financially eligible for*** Medicaid *[eligible beneficiary]*, the NF shall submit a ***completed*** Notification From Long-Term Care Facility of the Admission or Termination of a Medicaid Patient, ***also known as an*** LTC-2 *[Form in which a facility submits notification to the Long Term Care Field Office of an admission or discharge of a Medicaid eligible beneficiary (posted]* ***form, provided at Appendix G, incorporated herein by reference, and available for download*** at www.state.nj.us/health/ltc/formspub.htm *[) (see Appendix E)]* ***and at http://nj.gov/health/forms/index.shtml***, to the *[Long Term Care Field Office (]* LTCFO *[)]* serving the county *[where]* ***in which*** the NF is located *[, within two working days of admission]*.

1. The NF shall obtain ***from the appropriate CWA*** a statement of the *[Medicaid beneficiary's] ***individual's*** budgetary information on the *[PA-3L]* Statement of *[Income]* Available ***Income*** for Medicaid Payment *[(posted at www.state.nj.us/health/ltc/formspub.htm) (see Appendix F) from the appropriate CWA]* ***form, also known as form PA-3L, or form PR-1, provided at Appendix F, incorporated herein by reference***.

(d) Professional staff designated by the Department *[will review the]* ***shall conduct PAS by reviewing the individual's*** medical, nursing, and social information *[obtained at the time of assessment, as well as]* ***and*** any other supporting data, in order to assess the individual's care needs and determine the appropriate setting for the delivery of needed services. The professional staff designated by the Department will authorize or deny NF placement based on the *[service requirements of]* ***results of the standardized assessment performed by professional staff designated by the Department, in accordance with (e) below, that documents the individual's clinical eligibility pursuant to*** N.J.A.C. 8:85-2***.1*** and the feasibility of alternative placement***,*** and ***then, depending on the placement professional staff designated by the Department determine to authorize, if any, the staff*** will designate the track of care.

1. If alternative care is available, accessible, and appropriate to the needs of the individual, the request for NF placement will be denied.

    i. If an appropriate alternative plan of care becomes available and accessible for a person already approved for NF care and awaiting placement, the ***Department will rescind*** authorization for NF placement *[will be rescinded]* ***and will authorize the alternative plan of care***.

2. For each NF applicant with MI or MR *[who is determined to require]* ***whose standardized assessment and PAS results in a determination that the individual is clinically eligible for*** NF placement, the *[State mental health or mental retardation authority]* ***DMHS or the DDD***, as appropriate, will *[determine whether the individual requires specialized services for MI or MR]* ***conduct PASRR***, prior to ***the Department's*** issuance of *[the approval for]* ***a written determination authorizing*** NF placement.

    i. *[For the]* ***With respect to an individual with*** MI *[diagnosed individual, the professional staff designated by the Department shall request that]* ***seeking authorization for NF placement, the individual, or the individual's legal representative, social worker, or other entity referring the individual, or with respect to an individual with MI who is already a NF resident who is experiencing a change from the condition described on the resident's MDS, the NF, shall complete part 1 on page 1 and part A of page 6 of*** the Psychiatric Evaluation form *[that helps determine the need for specialized services for MI or MR patients and includes personal identification, clinical evaluation notes, diagnoses, lists of medications and referral information, (posted at www.state.nj.us/health/ltc/formspub.htm) (see Appendix G, incorporated herein by reference), provided by the mental health authority, be]* ***provided at Appendix I, incorporated herein by reference; shall have parts 2 through 9 beginning on page 1 and section B on page 6*** completed *[and forwarded to the Division of Mental Health Services for determination of need for specialized services. The evaluation shall be completed]* by a psychiatrist, physician (doctors of medicine or osteopathy)***,*** certified nurse practitioner *[(CNP)]* ***,**

certificated pursuant to N.J.S.A. 45:11-45 et seq., and certified in the advanced practice of psychiatric nursing or mental health,* or clinical nurse specialist *[(CNS). CNPs and CNSs must be]* ***, certificated pursuant to N.J.S.A. 45:11-45 et seq., and*** certified in the *[advance]* ***advanced*** practice of psychiatric *[/]* ***nursing or*** mental health *[. For individuals with a change of condition as defined by the MDS, a psychiatric consultant to the NF should complete the psychiatric evaluation]* ***; and shall send the completed form to the DMHS, which will conduct PASRR based upon the information provided in the Psychiatric Evaluation*** form.

(1) Individuals having a primary diagnosis of dementia including Alzheimer's disease are not subject to *[the State MI determination for specialized services prior to]* ***PASRR by DMHS as a precondition to a determination of Medicaid clinical eligibility for NF*** admission *[to the NF]*.

ii. *[For the]* ***With respect to an individual with*** MR *[diagnosed individual]*, the LTCFO will contact the appropriate *[DHS, Division of Developmental Disabilities (]* DDD *[)]* staff to *[complete the determination for specialized services]* ***conduct PASRR***. *[In the case of an individual dually diagnosed with MI and MR, the determination by the mental health authority will be completed first.]*

(1) Individuals with MR and a diagnosis of dementia including Alzheimer's disease are subject to *[the State MR determination for specialized services prior to]* ***PASRR by DDD as a precondition to a determination of Medicaid clinical eligibility for NF*** admission

iii. In the case of an individual dually diagnosed with MI and MR, the conduct of PASRR by DMHS shall precede the conduct of PASRR by DDD.

[iii.] ***iv.*** The *[results of the MI or MR]* ***DMHS and/or the DDD, as applicable, will each transmit its respective PASRR*** determination*[s *will be

forwarded]* to the LTCFO and *[will be conveyed] ***the LTCFO will transmit the PASRR determination*** to the *[referring]* individual ***or, if applicable, the individual's legal representative, or other referring entity***.

(1) If ***the PASRR results in a determination that*** no specialized services are required, the ***Department will approve NF placement and will issue a*** NF approval letter *[will accompany the MI/MR agency report]* ***to the individual or, if applicable, the individual's legal representative, in the form provided at Appendix M, incorporated herein by reference, and will enclose with the letter a copy of the PASRR determination***.

[iv. In the event] ***(2) If the PASRR results in a determination that*** the individual *[is determined by the State MI or MR authority to]* require***s*** specialized services ***for MI or MR***, ***then*** NF placement is inappropriate *[. The MI or MR authority]* ***and the Department will issue to the individual or, if applicable, the individual's legal representative, and the referring individual a letter denying Medicaid authorization for NF placement in the form provided at Appendix N, incorporated herein by reference, and the DMHS or the DDD*** will assist in finding appropriate placement *[/]* ***and/or*** services for the individual.

v. If ***PAS results in a determination that the individual is not clinically eligible for*** NF placement *[is denied based on failure to meet the NF]* ***pursuant to the*** requirements of N.J.A.C. 8:85-2***.1***, *[further screening by the State MI or MR authority]* ***PASRR*** is not required.

*[(e) As part of the PAS determination, the track of care will be designated based on the following criteria:

1. Track I designates long-term NF care and shall be assigned in situations in which long-term placement is required because clinical prognosis is poor, and in which, during the assessment process, it is determined that short-term stays

are neither realistic nor predictable. Individuals designated for Track I services shall, at a minimum, require nursing services as required by N.J.A.C. 8:85-2.

i. A Track I designation shall not preclude the possibility of future discharge. The professional staff designated by the Department will monitor those individuals with discharge potential, reassess the individual, and update the Health Services Delivery Plan (HSDP) for a track change if appropriate.

2. Track II designates short-term NF care and shall be assigned in those situations in which comprehensive and coordinated NF services are required to stabilize medical conditions, promote rehabilitation, or restore maximum functioning levels and to provide a therapeutic setting which assures family counseling and teaching in preparation for discharge to the community setting.

i. Individuals designated for Track II shall also be assigned to short-term NF stays, in spite of technically complex care needs and guarded prognosis, particularly in cases in which the individual is motivated towards NF alternatives and/or in which caregivers, through case management intervention, may obtain services that make return to the community a viable option.

3. Track III designates long-term care services in the community and shall be assigned in the case of individuals who meet the requirements of N.J.A.C. 8:85-2, but can be appropriately cared for in the community with supportive health care services. These individuals may be eligible for Medicaid State Plan services or Home and Community-Based Services Waiver Programs.]*

[(f)] ***(e)*** The following procedure is to be used by *[the]* ***a*** referent when seeking ***Medicaid*** authorization ***of NF placement*** through PAS prior to the admission of ***individuals who are financially eligible for*** Medicaid *[eligible individuals]* or *[for private pay]* individuals ***residing in a NF paying from private funds*** who may become eligible for Medicaid within *[six months]* ***180 days***.

1. *[The]* ***If the*** referent ***is a hospital, the hospital*** shall *[be responsible for identifying a potentially Medicaid eligible individual, a Medicaid eligible individual or an individual subject to PASARR requirements who may be at risk for NF placement pursuant to]* ***identify individuals who are or potentially are at risk for NF placement, including individuals with MI and/or MR who may require PASRR, by consulting*** the "At-Risk Criteria for Nursing Facility Placement" *[(posted at www.state.nj.us/health/ltc/formspub.htm) (see Appendix H]* ***, also known as form LTC-D1, provided at Appendix J***, incorporated herein by reference ***, and available for download at http://www.state.nj.us/health/forms***. *[). These individuals]* ***The hospital*** shall *[be referred]* ***refer such individuals*** to the LTCFO for a PAS *[assessment]* and, if appropriate, to the CWA for *[eligibility]* determination ***of financial eligibility. The hospital should submit to the LTCFO the completed Hospital Preadmission Screening Referral form, also known as form LTC-4, provided as Appendix T, incorporated herein by reference, and available for download at http://www.state.nj.us/health/forms and at www.state.nj.us/health/ltc/formspub.htm, to notify the LTCFO for PAS and, if appropriate, the CWA for determination of financial eligibility.***

   i. *[The professional]* ***Professional*** staff designated by the Department will conduct *[a]* PAS *[assessment utilizing]* ***using*** a standardized assessment instrument ***provided at Appendix K, incorporated herein by reference,*** and ***upon the conclusion of the assessment,*** shall verbally advise the referent***, the individual,*** and ***the individual's*** family *[/ authorized]* ***member or legal*** representative *[of the assessment decision]* ***as to whether the individual is clinically eligible for NF placement*** and *[, if appropriate, shall advise that an evaluation for PAS MI/MR specialized services]* ***whether PASRR*** is required. *[The Health Service Delivery Plan (]*

      ***(1) If the individual is clinically eligible for NF placement and does not require PASRR, then upon conclusion of PAS, the professional staff designated by the Department shall provide the referent with a**

copy of an executed approval letter in the form provided at Appendix M and a completed* HSDP *[) (posted at www.state.nj.us/health/ltc/formspub.htm), which identifies the individual's current and potential health problems and care needs, and signed approval/denial letter, as appropriate, shall be given to the referent. The]* ***in the form provided at Appendix L, and the LTCFO shall mail the*** original ***approval*** letter *[shall be sent by the LTCFO]* to the individual *[/family with copies]* ***, or, if applicable, the individual's legal representative, and shall send a copy of the approval letter*** to the CWA. *[For PAS MI/MR individuals, a signed approval letter and HSDP will only be forwarded to the individual/family, with a copy to the referent, after the determination has been made that no specialized services are required.]*

***(2)** **If the individual is clinically ineligible for NF placement, the LTCFO will mail a letter denying Medicaid authorization for NF placement in the form provided at Appendix N to the individual or, if applicable, the individual's legal representative and will mail a copy of the letter to the CWA.**

(3) **If the individual is clinically eligible for NF placement but PASRR is required, the professional staff designated by the Department shall provide the individual or the individual's legal representative, with written notice of the necessity of PASRR in the form provided at Appendix R, incorporated herein by reference, also known as form LTC-L6a, with respect to individuals with MI, and in the form provided at Appendix S, incorporated herein by reference, also known as LTC-L7a, with respect to individuals with MR.**

(4) **Upon conclusion of PASRR, if PASRR results in a determination that the**

individual does not require specialized services for MI or MR, then the LTCFO will mail the original approval letter in the form provided at Appendix M to the individual, or, as appropriate, to the individual's legal representative and to the referring individual, and will mail a copy of the executed approval letter and a completed HSDP in the form provided at Appendix L to the referent.

(5) Upon conclusion of PASRR, if PASRR results in a determination that the individual requires specialized services for MI or MR, then the LTCFO will mail a letter denying Medicaid authorization for NF placement in the form provided at Appendix N, incorporated herein by reference, to the individual or, as appropriate, the individual's legal representative, and the DMHS or the DDD, as appropriate, will assist in finding appropriate placement and/or services for the individual.*

[(1)] ***(6)*** If an individual being transferred from a hospital setting to a NF is or will be eligible for Medicare benefits, the transfer shall, to the extent possible, be made to a Medicare *[/]* ***and*** Medicaid participating *[(S)NF]* ***NF***.

2. *[The]* ***If the referent is a NF, the*** referent shall *[be responsible for identifying] ***refer an*** individual *[s who are currently residing in a Medicaid participating NF who may become eligible for Medicaid within six months. These individuals shall be referred via the]* ***no later than 180 days prior to the individual's anticipated date of Medicaid eligibility by submitting the completed Notification from Long-Term Care Facility of Admission or Termination of a Medicaid Patient form, also known as the*** LTC-2 form ***, provided at Appendix G, incorporated herein by reference, and available for download at www.state.nj.us/health/forms and at www.state.nj.us/ health/ltc/formspub.htm,*** to the LTCFO for *[a]* PAS *[assessment with]* ***and by submitting*** a

copy of the form *[sent]* to the CWA for ***a determination of financial*** eligibility *[determination]*.

[i. The NF shall refer such individuals to the LTCFO for a PAS evaluation no later than six months prior to the anticipated date of Medicaid eligibility.]

i. Professional staff designated by the Department will conduct PAS in accordance with the procedure provided in (d) above and by completing the standardized assessment.

ii. *[The] ***When the CWA determines that the individual is financially eligible for Medicaid, the*** CWA will forward the LTC-2 *[Form (Notification from Long-Term Care Facility of Admission or Termination of Medicaid Patient)]* ***form*** to the LTCFO indicating a change in the individual's status from private pay to ***financially eligible for*** Medicaid *[status]*.

3. *[Individuals]* ***A person or entity shall refer an individual*** residing in the community who *[are Medicaid-eligible beneficiaries or]* ***is seeking admission to a Medicaid-participating NF and*** who ***is financially eligible for Medicaid or who*** may become ***financially*** eligible for Medicaid within *[six months]* ***180 days*** of admission ***to a NF***, or an individual*[s subject to PASARR requirements as defined at 42 CFR 483.102, shall be referred]* ***with MI or MR,*** to the LTCFO for *[preadmission screening]* ***PAS*** and, if appropriate, to the CWA for ***a determination of financial*** eligibility *[determination, when seeking admission to a Medicaid participating NF]* ***by submitting to the LTCFO a completed Certification of Need for Patient Care in Facility other than Public or Private General Hospital, also known as a PA-4 form, provided at Appendix H, incorporated herein by reference, and available for download at http://nj.gov/health/forms/ index.shtml***.

i. Upon receipt by the LTCFO of a PA-4 *[Form (Certification of Need for Patient Care in Facility Other than Public or Private General Hospital)]* ***form*** or ***a*** physician statement *[which]* ***that*** substantiates ***the individual's*** diagnosis and describes the individual's care needs, *[a]* ***professional staff**

designated by the Department will conduct* PAS *[assessment will be conducted]* ***in accordance with the procedure provided in (d) above and by completing the standardized assessment***. *[The individual will receive notification from the LTCFO, in writing, of approval or denial of NF services. Copies]*

(1)** **Upon conclusion of PAS, the professional staff designated by the Department will verbally advise the individual or, if applicable, the individual's legal representative, as to whether the individual is clinically eligible for NF services, and the LTCFO will mail either the approval letter in the form provided in Appendix M, or the denial letter in the form provided in Appendix N, to the individual or, if applicable, the individual's legal representative, and will send a copy of the letter *[will be sent]* to the CWA.

ii. For individuals residing in the community *[who meet the PASARR/MI criteria, a]* ***with MI, professional staff designated by the Department will verbally advise the individual or, if applicable, the individual's legal representative, at the conclusion of PAS whether the individual is clinically eligible for NF placement.**

(1) **If the individual is not clinically eligible for NF placement, the LTCFO will mail an executed denial letter in the form provided at Appendix N to the individual or, if applicable, the individual's legal representative.**

(2) **If the individual is clinically eligible for NF placement, the professional staff designated by the Department will provide the individual or, if applicable, the individual's legal representative, with an executed form LTC-L6a advising the individual or representative, of the need to have the*** Psychiatric Evaluation form *[must be]* ***provided at Appendix I*** completed

[and forwarded to the Division of Mental Health Services or determination of need for specialized services. The evaluation shall be completed] by a psychiatrist, physician (doctors of medicine or osteopathy)***,*** certified nurse practitioner *[(CNP)]* ***certificated pursuant to N.J.S.A. 45:11-45 et seq., and certified in the advanced practice of psychiatric nursing or mental health*** or *[a]* clinical nurse specialist *[(CNS). CNPs and CNSs must be]* ***certificated pursuant to N.J.S.A. 45:11-45 et seq., and*** certified in the *[advance]* ***advanced*** practice of psychiatric *[/]* ***nursing or*** mental health *[(]* ***pursuant to*** N.J.S.A. 45:11-45 et seq.*[).]* ***and the need to forward the form to the DMHS.***

***(3) If PASRR by the DMHS results in a determination that the individual requires specialized services for MI, then NF placement is not appropriate and the LTCFO will mail an executed denial letter in the form provided at Appendix N and a copy of the PASRR determination to the individual or, if applicable, the individual's legal representative, and the DMHS will assist the individual in securing appropriate placement and/or services.**

(4) If PASRR by the DMHS results in a determination that the individual does not require specialized services for MI, the LTCFO will mail the approval letter in the form provided in Appendix M and a copy of the PASRR determination to the individual or, if applicable, the individual's legal representative, and will transmit a copy of the approval letter to the CWA.*

iii. For individuals residing in the community *[who meet the PASARR/MR criteria DHS, Division of Developmental Disabilities (]* ***with MR, professional staff designated by the Department will verbally advise the individual or, if applicable, the individual's legal representative, at the**

conclusion of PAS whether the individual is clinically eligible for NF placement.

(1) If the individual is not clinically eligible for NF placement, the LTCFO will mail, an executed denial letter in the form provided at Appendix N to the individual, or if applicable, the individual's legal representative.

(2) If the individual is clinically eligible for NF placement, professional staff designated by the Department will provide the individual or the individual's legal representative, with an executed form LTC-L7a advising the individual or representative, of the need for the* DDD *[) staff shall complete the evaluation for specialized services]* ***to conduct PASRR***.

***(3) If PASRR by the DDD results in a determination that the individual requires specialized services for MR, then NF placement is not appropriate and the LTCFO will mail an executed denial letter in the form provided at Appendix N and a copy of the PASRR determination to the individual or, if applicable, the individual's legal representative and the DDD will assist the individual in securing appropriate placement and/or services.**

(4) If PASRR by the DDD results in a determination that the individual does not require specialized services for MR, the LTCFO will mail the approval letter in the form provided in Appendix M and a copy of the PASRR determination to the individual or, if applicable, the individual's legal representative, and will transmit a copy of the approval letter to the CWA.*

iv. In the case of an individual dually diagnosed with MI and MR, *[the determination by the mental health authority will be completed first]* ***the conduct of***

PASRR by the DMHS shall precede the conduct of PASRR by the DDD*.

[(g)] ***(f)*** Authorization of out-of-State ***NF*** placement *[shall include]* ***is subject to*** the following additional conditions:

1. Prior authorization shall be obtained from the Department for out-of-State NF services and shall be considered only when a required long-term care service is not available in New Jersey.

2. The out-of-State facility shall be licensed ***under the laws of that state*** as a NF or SCNF ***or equivalent entity, howsoever labeled*** by that state, and the rate of reimbursement shall not exceed that authorized by the *[Title XIX]* ***Medicaid*** program *[in]* ***of*** the state in which the facility is located, or the reimbursement rate authorized by the New Jersey *[Health Services]* ***Medicaid*** Program *[(Medicaid)]*, whichever is lower.

3. Requests for prior authorization for out-of-State placement shall be accompanied by sufficient evidence *[of medical necessity to substantiate the request] ***that the service is medically necessary and not available in New Jersey***. The Department will review the records provided to determine the need for long-term care services and to determine the appropriateness of placing the beneficiary in a NF *[in]* ***outside of*** New Jersey. The request must be submitted to:

Office of Community Choice Options
Division of Aging and Community Services*
Department of Health and Senior Services
[Office of Long Term Care Options]
PO Box 807
Trenton, *[New Jersey]* ***NJ*** 08625-0807

4. Prior to submitting a request for out-of-State placement, the beneficiary shall comply with the requirements of *[the pre-admission screening process]* ***PAS*** as specified in this subchapter.

[(h)] ***(g)*** The procedure for ***Department authorization of Medicaid reimbursement for*** NF continued stay*[/ alternate]* ***or alternative*** care *[shall be]* ***is*** as follows:

1. The professional staff designated by the Department shall periodically assess Medicaid beneficiaries*[,]* ***to*** review the NF's assessments, patient classifications, and case mix reporting, and may recommend *[alternatives to NF stay or]* ***continuation of NF stay or, if appropriate,*** deny continued ***NF*** stay ***and shall recommend discharge to an alternative to NF stay***.

2. Professional staff designated by the Department shall *[, on an ongoing basis,]* provide care management ***on an ongoing basis*** to Medicaid beneficiaries following placement ***in a NF.*** *[to monitor the provision of NF care in order to:

   i. Assure that services are rendered as recommended by the HSDP and in accordance with the NF's evaluation of the individual's health service needs;

   ii. Assure the delivery of timely and coordinated services;

   iii. Provide, direct or secure needed consultations with Medicaid professional or NF staff so that services are coordinated, effective, and cost prudent; and

   iv. Facilitate discharge planning and promote appropriate placement to alternate care settings.]*

3. *[The professional]* ***Professional*** staff designated by the Department shall examine resident records for proof of continued vigilance and effort by the *[facility]* ***NF*** to utilize alternative means of care for all residents.

   i. Beneficiaries designated as Track II (short-term) shall be monitored closely by the Department to assure active participation by the *[facility]* ***NF*** in the discharge planning process.

[(i)] ***(h)*** If a NF resident *[who meets PASARR criteria as defined in 42 C.F.R §483.102 as amended and supplemented and incorporated herein by reference for MI/MR]* ***with MI or MR*** shows a significant change in condition as defined by the MDS, the NF shall initiate treatment to meet immediate needs. *[A]* ***The NF shall arrange for the conduct and completion of a*** comprehensive reassessment *[shall be completed]* by the end of the 14th day of the documented change in condition *[, noting]* ***. If the reassessment results in a finding*** that a significant change ***in the resident's condition*** has occurred *[. Within seven days of completing the reassessment]* , the *[facility]* ***NF*** shall revise the ***resident's*** care plan based on that reassessment *[. The NF]* ***within seven days of the completion of the reassessment,*** shall make

a clinical *[judgement]* ***judgment***, based on the clinical data, as to whether or not *[a PASARR review by the Division of Mental Health Services]* ***PASRR by DMHS*** or DDD is needed***, and if so, shall notify the DMHS and/or the DDD, as appropriate, of the need for PASRR***.

[(j)] ***(i) Professional staff designated by the Department, after considering and rejecting all possible means of alternative care, shall approve conventional NF placement for*** Medicaid beneficiaries residing in a NF approved for a SCNF rate of reimbursement who continue to require *[long-term supportive and restorative nursing services and therapeutic treatment for continued maintenance, in the absence of significant clinical change or complex service needs, shall be approved for conventional NF placement (adult or pediatric) by the Department after consideration and rejection of all possible means of alternate care]* ***NF level of nursing care, but who no longer require SCNF level of nursing care***.

[(k)] ***(j)*** The NF shall notify the LTCFO, via the LTC-2 *[Form]* ***form***, of the termination of *[nursing facility]* ***NF*** services due to *[the death of a resident,]* ***the beneficiary's:***

i. ***Death while*** either in the NF or *[while]* hospitalized; *[discharge]*

ii. ***Discharge*** to home or other community living arrangement; *[transfer]*

iii. ***Transfer*** to another NF; or *[ineligibility]*

iv. ***Ineligibility*** determination.

8:85-1.9 Waiting list

(a) The NF shall establish a single waiting list in chronological order. The order of names shall be predicated upon the order in which a completed written application is received. Hospitalized individuals ready for readmission to the NF are to be added to the top of the list as soon as the hospital notifies the NF of the contemplated discharge. As soon as a bed becomes available, it shall be filled from this waiting list. Provisions can be made for emergency, life-threatening situations or life-care community admissions or transfers from another nursing facility.

1. (No change.)

2. It shall be unlawful discrimination for any Medicaid participating NF whose Medicaid occupancy level is less than the Statewide occupancy level to deny admission to a Medicaid eligible individual who has been authorized for NF

services by the LTCFO when a NF bed becomes available in accord with the waiting list.

i. (No change.)

8:85-1.10 Involuntary transfer

(a) The Department recognizes that there may be problems in relocating infirm aged persons from a NF. The purpose of this rule is to specify the circumstances in which the involuntary transfer of a Medicaid beneficiary in a NF is authorized and to establish conditions and procedures designed to minimize the risks, trauma and discomfort which may accompany the involuntary transfer of a Medicaid beneficiary from a NF.

(b) (No change.)

(c) This rule shall apply to the involuntary transfer of a Medicaid beneficiary at the request of a NF. This rule shall not apply to the Department's utilization review process, nor to the movement of a Medicaid beneficiary to another bed within the same facility.

(d) A transfer of a Medicaid beneficiary which was not consented to or requested by the beneficiary or by the beneficiary's family or authorized representative shall be considered an involuntary transfer. A Medicaid beneficiary is a Medicaid eligible individual residing in a NF which has a Medicaid provider agreement. This includes Medicaid beneficiaries over the minimum number stipulated in the agreement or an individual who had entered the facility as non-Medicaid and is awaiting resolution of Medicaid eligibility.

(e) A Medicaid beneficiary shall only be involuntarily transferred when adequate alternative placement, acceptable to the Department, is available. A Medicaid beneficiary may be transferred involuntarily only for the following reasons:

1. (No change.)

2. The transfer is necessary to protect the physical welfare or safety of the beneficiary or other residents;

3. (No change.)

4. The transfer is required by the New Jersey State Department of Health and Senior Services pursuant to licensure action or to the facility's suspension or termination as a Medicaid provider.

(f) In any determination as to whether a transfer is authorized by this rule, the burden of proof, by a preponderance of the evidence, shall rest with the party requesting the transfer, who shall be required to appear at a hearing if one is requested and scheduled. Where a transfer is proposed, in addition to any other relevant factors, the following factors shall be taken into account:

1. The effect of relocation trauma on the beneficiary;
2. The proximity of the proposed placement to the present facility and to the family and friends of the beneficiary; and
3. (No change.)

(g) The procedure for involuntary transfer shall be as follows:

1. The NF shall submit to the LTCFO a written notice with documentation of its intention and reason for the involuntary transfer of a Medicaid beneficiary from the facility;
2. If the LTCFO determines that an involuntary transfer is appropriate, the beneficiary and/or the beneficiary's authorized representative shall be given 30 days prior written notice by the NF that a transfer is proposed by the NF and that such transfer will take effect upon completion of the relocation program specified in (h) below. Additionally, the NF shall forward a copy of the written notice to the LTCFO and Ombudsman. The written notice to the beneficiary and/or authorized representative shall advise of the right to a hearing and shall include the address where to send the request for a hearing. If the beneficiary requests a hearing within 30 days of the date of the written notice, the transfer is stayed pending the decision following the hearing. In those instances where the LTCFO determines that an acute situation or emergency exists, the transfer shall take place immediately. The beneficiary and/or the beneficiary's authorized representative shall be given 30 days after transfer to request a hearing;
3. DMAHS will comply with the hearing time requirements in State and Federal rules and regulations, unless an adjournment is requested by the appellant;
4. The hearing shall be conducted at a time and place convenient to the beneficiary. Notification shall be sent to all parties concerned;
5. All hearings shall be conducted in accordance with the Fair Hearing procedures adopted by the DMAHS.

(h) The relocation procedure shall be as follows:

1. In the event the relocation of a beneficiary is the final Department determination, the Department shall afford relocation counseling for all prospective transferees in order to reduce as much as possible the impact of transfer trauma.

2. The staff of the transferring and receiving NFs shall carry out the transfer process, although responsibility and authority for the coordination and transfer rests with the Department and will include:

i. Evaluation and review by appropriate LTCFO staff;

ii. Initial beneficiary, family or authorized representative counseling;

iii. Involvement of the beneficiary, family or authorized representative in the placement process with recognition of their choices;

iv. Beneficiary preparation and site visit for all able to do so within the capability of the transferring agent;

v. Accompaniment on the transfer day by a family member, authorized representative or attendant, unless the beneficiary otherwise requests;

vi.-vii. (No change.)

(i) No owner, administrator or employee of a NF shall attempt to have beneficiaries seek relocation by harassment or threats. Such action by or on behalf of the NF may be cause for the curtailment of future admission of Medicaid beneficiaries to the NF or for termination of the Medicaid Provider Agreement with the NF, depending upon the nature of the action.

(j) Any complaints regarding the handling of beneficiaries relative to their transfer shall be referred to the Department for investigation and corrective action.

8:85-1.11 (Reserved)

8:85-1.12 Clinical audit

(a) (No change.)

(b) Professional staff designated by the Department shall periodically conduct a post payment review of New Jersey Medicaid

beneficiaries for whom NF services have been provided. The review shall principally involve assessment of the Medicaid beneficiary's care needs and evaluation of treatment outcomes, based on direct observation of the beneficiary and examination of clinical and related records. The focus of the review shall be on the following areas:

1. Comparative analysis of a beneficiary's identified care needs to NF claim reports;

2.-3. (No change.)

(c) Enforcement action will be taken by the Department as follows:

1.-2. (No change.)

8:85-1.13 Clinical and related records

(a) An individual clinical record shall be maintained for each Medicaid beneficiary covering his or her medical, nursing, social and related care in accordance with accepted professional standards and licensing standards as set forth by the *[Department 's]* ***Standards for Licensure of*** Long***-***Term Care Facilities *[Licensing Standards]*, N.J.A.C. 8:39. All entries on the clinical record shall be current, dated and signed by the appropriate staff member. The clinical record, HSDP approval letter and if appropriate, *[the PASARR evaluation]* ***PASRR determination*** shall be readily available at the appropriate nurses' station for review by DHSS staff.

(b)-(c) (No change.)

(d) If the resident is transferred to or from another health care facility***,*** a copy of the resident***'s*** clinical record or an abstract thereof, including the most recent HSDP, *[SRA]* ***MDS*** and ***, if applicable,*** current copy of *[PASARR Specialized Service review for MI/MR individuals]* ***the resident's PASRR, and/*** or the documentation *[which]* ***that*** supports the ***resident's*** diagnosis *[for individuals with]* ***of*** Alzheimer's disease or related organic dementia, shall accompany the resident.

(e)-(f) (No change.)

(g) Billing and financial records rules are as follows:

1. The Fiscal Agent Billing Supplement identifies the procedures required for the general use of the billing transaction forms and computer generated forms. All appropriate reports shall be retained until audited by the Department.

2. The facility shall establish and maintain appropriate and accurate records and accounts of all receipts and disbursements of Medicaid beneficiary funds, which shall be subject to review and fiscal audit by the State of New Jersey as may be required. A beneficiary shall be credited with the maximum amount of personal needs allowance funds authorized by Federal or State law for each month that such records or accounts are unavailable.

3. Any and all financial and other records relating to beneficiary's personal needs allowance accounts, income, cost reports, and billings to the Medicaid program shall be maintained and retained in accordance with professional standards and practices for the longest of the following periods of time:

   i.-iii. (No change.)

4. (No change.)

5. Claims for NF services that are older than 12 months will be rejected.

   i. A claim for payment for services shall be received by the fiscal agent no later than one year after the "from date of service" on the claim form (TAD). An adjustment request FD999 (see Appendix Q) for a paid claim shall be honored for *[a period of six months]* ***180 days*** from the original date of payment;

   ii. For purposes of this time limitation, a claim is the submission of a TAD, provided by the fiscal agent for the New Jersey Medicaid program, indicating a request for reimbursement for authorized NF services provided to an eligible beneficiary and which has been returned to the fiscal agent within the time limit specified. An adjustment form (FD999) or an LTC-2 shall not constitute a claim for payment;

   iii. Other timely filing information is located in the Administrative chapter at N.J.A.C. 10:49-7.2, *["]*Timeliness of claim submission and inquiry*["]*.

8:85-1.14 Absence from facility due to hospital admission or therapeutic leave; bed reserve

(a) The bed reserve policy for hospital admissions is as follows:

1. The NF shall reserve and hold the same room and the same bed of the Medicaid beneficiary transferred to a general or psychiatric hospital for a period not to exceed 10 days. The NF shall determine the individual's status or whereabouts during or after the 10-day bed reserve period.

    i. If the resident is not readmitted to the same room or the same bed or the same NF during a bed reserve period, the NF requesting bed reserve reimbursement shall record on the resident's chart and make available for Department review, a justification for the action taken. Pending outcome of the Department's review, the facility may be subject to forfeiture of bed reserve reimbursement.

    ii. Said reserved bed shall remain empty and shall not be occupied by another individual during the bed reserve period, unless authorized by the Department.

2. Reimbursement, not to exceed 10 days, shall be at *[90]* ***50*** percent of the rate the NF received prior to the transfer to the hospital.

    i. The beneficiary's available monthly income shall be applied against the per diem cost of care.

    ii. Medicaid reimbursement for bed reserve will not be made to a NF when the NF per diem payment for a "Medicaid eligible beneficiary" is being made by a third party insurer.

    [iii. When a Medicaid beneficiary is transferred back to the NF and then readmitted to a general or psychiatric hospital, the NF will not be reimbursed for an additional 10 day bed reserve if the Medicaid beneficiary was not in the NF for at least 24 hours prior to being readmitted to the hospital.]

3. If readmission to the NF does not occur until after the 10-day bed reserve period, the next available bed shall be given to the Medicaid beneficiary. The beneficiary's name shall be placed on the chronological listing of persons waiting admission/readmission to the NF, and the beneficiary waiting for readmission shall have priority for the next available bed in the facility.

4. The bed reserve policy applies to any person in the NF eligible to receive Medicaid benefits; for example, a Medicare/Medicaid beneficiary who, at the time of transfer to

the hospital, might be eligible for long-term care services under Medicare benefits.

5. Admission procedures (see N.J.A.C. 8:85-1.8) shall be followed when the Medicaid beneficiary has been readmitted following a period of hospitalization.

(b) Requirements concerning absence due to therapeutic leave are as follows:

1. The New Jersey Medicaid program will reimburse NFs their per diem rate for reserving beds for Medicaid beneficiaries who are absent from the facility on therapeutic leave up to a maximum of 24 days annually. For this purpose, annually is defined as a calendar year beginning on January 1 and ending on December 31. Further, no portion of unused leave days may be carried over into the next calendar year. The facility shall maintain accurate leave day records on the Medicaid beneficiary's chart, for review by the Department.

2. (No change.)

3. The absence of a Medicaid beneficiary from the facility for the purpose of therapeutic leave shall be authorized in writing by the beneficiary's attending physician and shall be included in the beneficiary's plan of care.

4. In those instances where a beneficiary is in more than one NF within a calendar year, the receiving facility shall determine the number of therapeutic leave days that have been allowed for payment by the sending facility within the same calendar year. A record of any leave days shall be a part of the information provided on the Patient Information Transfer Form.

5. The facility shall reserve and hold the same room and bed for the Medicaid beneficiary on a therapeutic home visit. Said bed shall not be occupied by another individual during the period of time in which the Medicaid beneficiary is on such leave.

6. Where a beneficiary's condition or situation requires more than 24 therapeutic leave days annually, as determined by the beneficiary's attending physician, prior authorization for the additional days shall be obtained from the LTCFO. The request for prior authorization shall be submitted in writing to the LTCFO Field Office Manager, over the signature of the attending physician. A facility shall be reimbursed its per

diem rate for reserving a bed for a Medicaid beneficiary for any additional days so authorized.

8:85-1.15 Complaints

(a) The Department will receive, document and investigate complaints from multiple sources and take appropriate corrective action as required. It is the Department's policy that the source of the complaint be held confidential, unless disclosure permission is obtained from the complainant.

(b) In addition to investigation by the Department, when complaints against a facility indicate the facility's failure to correct previously reported survey deficiencies or to comply with established licensure and Medicare/Medicaid certification standards, such complaint reports will be forwarded to the Office of the Ombudsman for the Institutionalized Elderly for review and action. Any complaints or reports received by the Department indicating legal violations will be referred to the office of the Attorney General for review and action, as required.

8:85-1.16 Utilization of resident's income for cost of care in the NF and for PNA

(a) After provision for the resident's Personal Needs Allowance (PNA) is met, and then after provision for other allocations such as maintenance of spouse and/or dependent's home are satisfied, the remainder of the Medicaid beneficiary's income shall be applied to the cost of care in the NF, which includes per diem, bed reserve and other allowable expenses.

1. The amount of income which shall be collected by the NF from the beneficiary, beneficiary's family or Representative Payee (if any) will be established in the process of determining eligibility and identified by form PA-3L, Statement of Income Available for Medicaid Payment, issued by the CWA. The NF shall collect all of the recipient's income to offset the Medicaid payment.

2. (No change.)

3. The New Jersey Medicaid program encourages families or any other concerned individual(s) to make voluntary monetary contributions to the State of New Jersey on behalf of Medicaid beneficiaries residing in nursing facilities. Inquiries should be directed to the Division of Senior Benefits and Utilization Management, Office of Administration and Finance, PO Box 722, Trenton, New Jersey 08625-0722.

(b) For all institutionalized aged, blind, and disabled individuals who are eligible for Medicaid, a designated amount of income as determined by State law (N.J.S.A. 30:4D-6a) shall be protected for personal needs allowance.

1. Certain individuals in a NF have no income, or insufficient income to provide a maximum amount of PNA. For those individuals not already deemed eligible for SSI, the facility shall insure that the application for SSI benefits has been made. PA-3L's for those beneficiaries who only receive an SSI check can be obtained from the Division of Senior Benefits and Utilization Management, Office of Provider Relations, PO Box 722, Trenton, New Jersey 08625-0722.

2. Once the NF initiates billing for a Medicaid beneficiary, that Medicaid beneficiary shall be considered a Medicaid beneficiary for the full term of stay in the NF (that is, until death or physician discharge) unless the patient loses eligibility during the stay or the beneficiary or authorized representative submits to the LTCFO, prior to death or discharge, a notarized statement to terminate benefits.

   i. After a beneficiary dies or is discharged, under no circumstances shall that beneficiary's Medicaid billing status be terminated prior to the date of death or discharge for the purpose of avoiding utilization of available income against cost share.

(c) Each Medicaid beneficiary residing in a NF shall be permitted to accumulate a sum of money from the PNA which, when combined with other resources retained by or for the person, does not exceed the maximum resource standard in the Department of Human Services Medicaid Only Manual at N.J.A.C. 10:71-4.5.

1. If the NF is handling the PNA, the facility shall closely monitor the PNA account and inform the beneficiary and/or his or her representative when the amount comes within $200.00 of the resource eligibility cap. If the PNA is in excess of the resource standard defined in N.J.A.C. 10:71-4.5, the beneficiary and/or his or her representative shall be advised of his or her right to reduce the excess monies and that the beneficiary may be terminated from Medicaid coverage, unless the amount in excess of the resource standard is expended.

2. The beneficiary may choose to reduce excess PNA by applying some of the accumulated PNA toward past expenditures paid for his or her care by the Medicaid program. Checks payable to the "Treasurer, State of New Jersey", may be directed to the Division of

Senior Benefits and Utilization Management, Office of Administration and Finance, PO Box 722, Trenton, New Jersey 08625-0722.

(d) (No change.)

(e) The personal needs allowance (PNA) shall be used as follows:

1. The PNA is intended to meet the personal and incidental needs of a beneficiary residing in a NF, in keeping with his or her wishes. The PNA is not intended to be applied against outstanding balances for the cost of care.

2. The NF shall not charge for items the beneficiary has not requested, nor for any items about which the beneficiary has not been informed in advance that he or she will be billed.

3. NFs shall not charge for any item or service reimbursable under the Medicaid program. A facility may charge the difference between the cost of the brand a beneficiary requests and the cost of the brand generally provided by the facility, if the facility chooses to provide the requested brand. NFs shall not require the purchase of non-covered items as a condition for admission.

4. The basic items that NFs shall make available for beneficiary use under the Medicaid program include:

i.-iv. (No change.)

5.-6. (No change.)

7. The PNA may be used to continue a bed reserve, if a beneficiary transferred to a hospital is unable to return within the 10-day bed reserve period. Payment shall be strictly voluntary, however, and shall be permitted only when the beneficiary's right to return to the NF (see N.J.A.C. 8:85-1.4) has been fully explained to the beneficiary and his representative. The beneficiary's request to use the PNA for this purpose shall be in writing. Under no circumstances shall the facility use overt or implicit coercion in this matter.

(f) A uniform accounting system shall be maintained by the facility as follows:

1. In compliance with Federal and State rules and regulations, the NF shall accept fiduciary responsibilities for a Medicaid beneficiary's PNA if the beneficiary and/or authorized

representative requests that his or her PNA be managed by the facility. The NF shall establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each beneficiary's personal funds entrusted to the facility on the beneficiary's behalf. In compliance with Federal and State rules and regulations, the facility shall deposit any resident's personal funds in excess of $ 50.00 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts. The facility shall credit all interest earned on the resident's account to his or her account.

2. The PNA account and related supporting information, such as receipts, canceled check, bank statement, check register shall be maintained at the facility. The Department recommends that a direct deposit system be utilized.

3. (No change.)

4. A subsidiary ledger shall be established whereby each beneficiary's deposits and disbursements are recorded and the total of the beneficiary's balances reconciled to the general ledger control account each month, or as last reported by the banking facility.

5. When recording the beneficiary's income in a cash receipts journal, the PNA shall be segregated from the available income applied to the cost of the beneficiary's care. Within five days of receipt, the PNA shall be deposited directly into the interest bearing checking or savings account restricted for PNA. The general ledger control account shall reflect a credit posting to indicate the total PNA received during the month. Each beneficiary's subsidiary ledger account shall also be posted to record the deposits to the appropriate account.

6. To facilitate the beneficiary's access to the PNA, a portion of the total cash may be transferred periodically from the segregated checking/savings account to a petty cash fund. The amount of the fund shall be reasonable and necessary for the size of the facility and needs of the beneficiaries.

7. In compliance with Federal and State rules and regulations, the facility shall provide, at least quarterly, to the beneficiary and/or his or her authorized representative, an accounting of all transactions with regard to the PNA account. The amount of balance in the beneficiary's account shall be available for the beneficiary and/or his or her authorized representative on request.

8. Management of funds shall be as follows:

   i. For beneficiaries who are able to manage their funds, a family member must have authorization in writing from the beneficiary/authorized representative for a specific amount before funds are disbursed from the PNA.

   ii. Beneficiaries who are unable to manage their funds should have representative payees appointed.

   iii. Family members should withdraw funds only on presentation of receipts showing items purchased for the beneficiary, unless this appears to be a financial hardship for the family member.

   iv. In cases where there is an outside representative payee, and the beneficiary appears to be denied access to his or her PNA funds, or personal items are not being purchased for him or her, the facility shall take steps to ensure that the beneficiary's right to his or her PNA benefits is restored. Such steps may include warning letters to the representative payee, use of the NF attorney, and/or referrals to the Office of the Ombudsman for Institutionalized Elderly and the Social Security Administration. In such cases, the facility may wish to request representative payeeship.

   9. When drawing checks or cash to make disbursements from the beneficiary's PNA account, either an original invoice or a signed receipt from the beneficiary or an authorized representative shall be retained by the facility and referenced to the beneficiary's account. The receipt must stipulate the use of the funds or specify the items purchased.

10. When the facility draws checks on behalf of a beneficiary or reimburses the petty cash fund, disbursements of PNA shall be segregated from the operating expenses of the facility. At the end of each month, the general ledger control account shall be charged for the total PNA disbursed and each beneficiary's subsidiary ledger account shall reflect the monthly disbursements on that beneficiary's behalf.

11. Accumulated interest is the property of the beneficiary. Although a beneficiary's PNA may not be used for banking service charges, interest from the account may be used for this purpose.

12. Upon discharge or transfer to another NF or other place of residence, the facility shall provide the beneficiary with a final accounting statement and a check in the amount of the beneficiary's close-out balance within seven working days of the transfer; however, a beneficiary transferred to another NF shall be given the option of authorizing the sending facility in writing to transfer any balance to the beneficiary's account at the receiving facility. The transfer of a PNA account from one facility to another shall be documented in writing, with a copy given to the beneficiary and/or his or her authorized representative. A beneficiary discharged or transferred shall have the right to the return of his or her personal property, such as, television, radio or other items.

13. Unclaimed PNA funds left behind by a discharged beneficiary who cannot be located or where the authorized representative cannot be located, shall be forwarded within 30 days to the Bureau of Administrative Control, Mail Code #6, PO Box 712, Trenton, New Jersey 08625-0712.

14. Within 10 days after the death of a Medicaid beneficiary, whether death occurred in the NF, in a hospital, or during a period of therapeutic leave, the NF shall send a written notice regarding the existence of PNA funds both to the CWA and the individual identified by the beneficiary as the person to contact.

A NF shall exercise all reasonable efforts to locate and notify any family, representative payee or interested person acting on behalf of the deceased Medicaid beneficiary.

i. The facility shall advise the contact person or responsible person that any claims made for PNA funds must be directed to the NF. When no CWA claim exists, the executor(rix) or administrator(rix), upon presentation of a letter of administration from the County Surrogate's Office, must be issued a check made payable to the estate of the deceased Medicaid beneficiary for the PNA funds. A check for the funds shall not be issued unless a Surrogate's letter is presented, except when a beneficiary dies intestate, leaving no surviving spouse, and the total value of the estate is less than $ 5,000; in such case, an affidavit of administration in accordance with N.J.S.A. 3B:10-4 is acceptable.

ii. (No change.)

iii. If no claim for PNA funds is made to the NF within 30 days of death, a check made payable to the "Treasurer, State of New Jersey" shall be forwarded to the Bureau of Administrative Control, Mail Code #6, PO Box 712, Trenton, New Jersey 08625-0712. The following information shall be included:

(1) An identification of the funds as unclaimed PNA funds of the deceased Medicaid beneficiary;

(2) Beneficiary's name;

(3)-(4) (No change.)

(5) Amount enclosed for that beneficiary.

iv. If a claim is received by the NF after the PNA funds have been forwarded to the Bureau of Administrative Control and within five years of the Medicaid beneficiary's death, the claim must be referred to the Bureau for processing. After five years, all claims received by the NF must be referred to the State Treasurer.

v. Any transactions involving distribution of a deceased Medicaid beneficiary's PNA funds must appear on the NF's record for audit purposes.

(g) Questions regarding personal needs allowance administration, for example, procedures, policy, or use of funds, should be directed to the Department:

Division of Long Term Care Services
PO Box 367
Trenton, New Jersey 08625-0367

8:85-1.17 Residents rights

(a)-(b) (No change.)

(c) The NF shall notify each resident of his or her right under State law to make decisions concerning his or her medical care and his or her right to formulate an advance directive in compliance with the New Jersey Advance Directives for Health Care Act, N.J.S.A. 26:2H-53 et seq., and the advance directive provisions of the Omnibus Reconciliation Act of 1990, effective December 1, 1991 and Department of Health and Senior Services licensing requirements at N.J.A.C. 8:39-9.5.

8:85-1.18 Medicaid/Medicare

(a) The New Jersey Medicaid Program will reimburse for NF services provided to combination Medicare/Medicaid beneficiaries only after Medicare covered benefits have been fully utilized or when medically necessary services are not covered by the Medicare Program. (Exceptions--see (f)1i below.)

1.-2. (No change.)

(b) Only skilled nursing facilities (SNFs), as defined in N.J.A.C. 8:85-1.2, certified by the Centers for Medicare & Medicaid Services (CMS) and the New Jersey Department of Health and Senior Services are eligible to be

reimbursed by Medicare for services rendered consistent with all Medicare requirements.

(c)-(d) (No change.)

(e) When Medicare benefits are denied, terminated or exhausted, because of coverage limitations, Medicaid may be billed on behalf of eligible beneficiaries,provided that:

1.-2. (No change.)

(f) Medicare Part A coinsurance may be paid by the New Jersey Medicaid Program, but the total combined Medicare/Medicaid reimbursement may never exceed the facility's Medicaid Nursing Facility rate. If the Medicaid beneficiary has available income during the coinsurance period of Medicare eligibility, it shall be used to offset the coinsurance charges, prior to billing Medicaid. New Jersey Medicaid will pay Part B Medicare insurance premiums for all eligible Medicare-Medicaid beneficiaries. Claims for Part B services shall be billed to Medicaid only after Medicare benefits have been exhausted. Medicare timely filing requirements shall be met prior to the reimbursement of coinsurance by Medicaid.

1. (No change.)

SUBCHAPTER 2 NURSING FACILITY SERVICES

8:85-2.1 Nursing facility services; eligibility

(a) Eligibility for nursing facility (NF) services will be determined by the professional staff designated by the Department, based on a comprehensive needs assessment which demonstrates that the beneficiary requires, at a minimum, the basic NF services described in N.J.A.C. 8:85-2.2.

1. Individuals requiring NF services may have unstable medical, emotional/behavioral and psychosocial conditions which require ongoing nursing assessment, intervention and/or referrals to other disciplines for evaluation and appropriate treatment. Typically, adult NF residents have severely impaired cognitive and related problems with memory deficits and problem solving. These deficits severely compromise personal safety and, therefore, require a structured therapeutic environment. NF residents are dependent in several activities of daily living (bathing, dressing, toilet use, transfer, locomotion, bed mobility, and eating). Dependency in activities of daily living (ADL) may have a high degree of individual variability. Each separate

ADL may be classified as either independent, requiring some assistance, or totally dependent.

i. (No change.)

2. (No change.)

(b) All Medicaid participating NFs shall provide or arrange for services in accordance with statutory and regulatory requirements under 42 CFR 483 and Department of Health and Senior Services licensing rules at N.J.A.C. 8:39. Reimbursement of NF services is discussed in N.J.A.C. 8:85-3.

(c) (No change.)

8:85-2.2 Delivery of nursing services

(a) The NF shall provide 24-hour nursing services in accordance with the Department's minimum licensing standards set forth by the *[New Jersey Department of Health]* ***Standards for Licensure of*** Long***-***Term Care Facilities *[Licensing Standards]*, N.J.A.C. 8:39, *[which is]* incorporated herein by reference *[. Employing and employ]* ***, employing*** the service-specific case mix system to classify recipients with similar care requirements and resource utilization. The NF shall provide nursing services by registered professional nurses, licensed practical nurses and nurses aides ***based*** on *[the basis of]* the total number of residents multiplied by 2.5 hours *[/]* ***per*** day; plus the total number of residents receiving each of the following services***, as more fully described at (f) below***:

1. Wound care	0.75 hour*[s/]* ***per*** day
2. *[Nasogastric tube]* ***Tube*** feeding*[s and/or gastrostomy]*	1.00 hour*[s/]* ***per*** day
3. Oxygen ***therapy***	0.75 hour*[s/]* ***per*** day
4. Tracheostomy	1.25 hour ***s*** *[/]* ***per*** day
5. Intravenous therapy	1.50 hour***s*** *[/]* ***per*** day
6. Respiratory services	1.25 hour***s*** *[/]* ***per*** day
7. Head trauma stimulation	1.50 hour***s*** *[/]* ***per*** day

[/] ***; and*** advanced neuromuscular*[/]* ***or*** orthopedic care

(b) The NF level of nursing care means services provided to Medicaid beneficiaries who are chronically or sub-acutely ill and require care for these entities, disease sequela or related deficits.

(c) The NF level of nursing care shall incorporate the principles of nursing process which consists of ongoing assessment of the beneficiary's health status for the purpose of planning, implementing and evaluating the individual's response to treatment.

1. In his or her capacity as coordinator of the interdisciplinary team, the registered professional nurse, who has primary responsibility for the beneficiary, shall perform, beginning on the day of admission, a comprehensive assessment of the beneficiary to provide, communicate and record within the SRA: baseline data of physiological and psychological status; definition of functional strengths and limitations; and determination of current and potential health care needs and service requirements.

   i. In addition to clinical observations and hands-on examination of the Medicaid beneficiary, the licensed nurse shall review the HSDP and any available transfer records. The assessment data shall be coordinated by the registered professional nurse with oral or written communication and assessments derived from other members of the interdisciplinary team and shall be consistent with the medical plan of treatment. The initial comprehensive assessment (SRA) shall be completed no later than 14 days after admission and on an annual basis thereafter. If there is a significant change in the beneficiary's status, the NF shall complete a full comprehensive assessment involving the SRA. The registered professional nurse shall analyze the data and utilize the resident assessment protocols (RAPs) to focus problem identification, structure the review of assessment information and develop an interdisciplinary care plan which documents specific interventions unique to the individual, which define service requirements and facilitate the plan of treatment.

2. The interdisciplinary care plan shall identify and document the beneficiary's problems and causative or contributing factors and is derived from the comprehensive assessment. The plan shall be coordinated and certified by the registered professional nurse with active participation of the Medicaid beneficiary and/or significant other. The scope of the plan shall be determined by the actual and anticipated needs of the Medicaid beneficiary and shall include: physiological, psychological and environmental factors; beneficiary/family education; and discharge planning. The care plan shall be a documented, accessible record of individualized care which reflects current standards of professional practice and includes:

   i.-iii. (No change.)

   iv. The initial interdisciplinary care plan shall be completed and implemented within 21 days of admission and shall be reviewed regularly and revised as often as necessary, according to all significant changes in a beneficiary's condition and to attainment of and/or revisions in objectives as indicated. Review and appropriate revision shall be done at least every three months and whenever the clinical status of the beneficiary changes significantly or requires a change in service provision.

3. Implementation of the interdisciplinary care plan and delivery of nursing care shall be documented within nursing progress (clinical) notes, which shall establish a format for recording significant observations or interaction, unusual events or responses, or a change in the Medicaid beneficiary's condition, which requires a change in the scope of service delivery. Specific reference shall be made to the beneficiary's reactions to medication and treatments, rehabilitative therapies, additional nursing services in accordance with N.J.A.C. 8:85-2.2(a), observation of clinical signs and symptoms, and current physical, psychosocial and environmental problems. Nursing entries shall be made as often as necessary, based on the Medicaid beneficiary's condition and in accordance with the standards of professional nursing practice.

4. Assessment review is the process of ongoing evaluation of health service needs and delivery. Nursing actions shall be analyzed for effectiveness of care plan implementation and achievement of objectives. The registered professional nurse, along with the Medicaid beneficiary and/or significant

other, shall participate with the team in the ongoing process of evaluation, reordering priorities, setting new objectives, revision of plans for care and the redirection of service delivery.

i. The assessment review process shall be conducted quarterly. Conclusions shall be documented on the SRA quarterly review, and the interdisciplinary care plan shall be updated to provide a comparison of the Medicaid beneficiary's previous and present health status, and to outline changes in service delivery and nursing interventions. The assessment review shall identify the effectiveness of, and the Medicaid beneficiary's response to, therapeutic interventions, and, whenever possible, the reason for any ineffectiveness in beneficiary responses.

(d) Restorative nursing is a primary component in the NF level of nursing care. Restorative nursing addresses preventable deterioration and is directed toward assisting each beneficiary to attain the highest level of physical, mental, emotional, social and environmental functioning. Restorative nursing functions shall include:

1.-11. (No change.)

(e) (No change in text.)

(f) Nursing services requiring additional nursing hours *[above the 2.5 hour staffing requirement]* ***pursuant to (a)1 through 7 above, in excess of those services included in NF level of nursing care as that term is described in (b) through (e) above,*** are *[set forth in]* ***described at*** (f)1 through 7 below. An individual beneficiary may require one or more additional nursing services, however, each category of additional nursing service may only be counted once for each individual beneficiary.

1. Wound care (***0***.75 hour*[s]* ***per day***), which includes, but is not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites and tumor erosion sites. In this category are Stage II pressure sores encompassing two or more distinct lesions on separate anatomical sites, Stage III and Stage IV pressure sores.

   i.-ii. (No change.)

2. Tube feeding*[s]* (1.00 *[hr/day]* ***hour per day***), which include***s*** nasogastric tube***s***, *[and]* percutaneous feedings *[may be used only if the feedings are providing the

individual with 51 percent or more calories or 26 to 50 percent calories and 501 cubic centimeters or more of enteral fluid intake per day]* and ***the routine care of the tube site and surrounding skin of the surgical gastrostomy, provided that*** all non-invasive avenues to improve the nutritional status have been exhausted with no improvement *[. The]* ***; NF staff shall document in the*** clinical record *[shall document]* the non-invasive measures provided *[and]* ***,*** the individual's poor response *[. The record shall also indicate] ***and*** the medical condition for which the feedings are ordered *[. Included in this service is the routine care of the tube site and surrounding skin of the surgical gastrostomy.]* ***; and the feedings are providing the individual with either 51 percent or more calories per day, or 26 to 50 percent calories and 501 milliliters or more of enteral fluid intake per day.***

i. Feeding tubes that do not meet the dietary administration and nutritional support criteria as stated in *[(g)2]* ***(f)2i or ii*** above are covered under *[the basic]* ***NF level of*** nursing *[service]* ***care*** and *[shall not be]* ***are not*** counted as an additional nursing service.

3. Oxygen therapy (***0***.75 *[hrs/day]* ***hours per day***), which includes the provision of *[continuous]* ***episodic*** oxygen therapy to increase the saturation of hemoglobin (Hb) without risking oxygen toxicity in beneficiaries with airway obstructive conditions such as asthma, chronic obstructive pulmonary disease or heart failure. The beneficiary requires *[continuous]* ***frequent, recurring, and ongoing*** pulse oximetry monitoring. The licensed nurses assess lung function and the beneficiary's symptoms that require intervention by the physician, physician assistant or advanced practice nurse.

4. Tracheostomy (1.25 *[hrs/day]* ***hours per day***), which includes *[new]* ***:***

i. ***New*** tracheostomy sites *[and complicated]* ***;***

ii. ***Complicated*** cases involving ***either*** symptomatic infections *[and]* ***or*** unstable respiratory functioning *[and deep]* ***; or***

iii. ***Frequent, recurring, and ongoing*** suctioning.

5. Intravenous *[Therapy]* ***therapy*** (1.50 *[hrs/day]* ***hours per day***), which includes ***(b)5i, ii, or iii below, provided***

that, when clinically indicated, intravenous medications are appropriately and safely administered within prevailing medical protocols; and, if intravenous therapy is for the purpose of hydration, NF staff shall document in the clinical record all preventive measures and attempts to improve hydration orally, and the individual's inadequate response.*

i.** **The administration and maintenance of clinically indicated therapies ***by the NF,*** as ordered by the physician, such as *[central venous lines, Hickman/Broviac catheters, heparin locks,]* total parenteral nutrition, *[elysis]* ***clysis***, hyperalimentation, and peritoneal dialysis *[. This includes the]* ***;***

ii.** **The administration of fluids or medications by the NF, as ordered by the physician, by means of lines or ports such as central venous lines, Hickman/Broviac catheters, or heparin locks and the flushing and dressing thereof; or

iii.** **The flushing and dressing of *[the central venous]* lines ***or ports such as central venous lines, Hickman/Broviac catheters, or heparin locks, by the NF, as ordered by the physician, for an identified treatment purpose and usage timeframe***. *[When clinically indicated, intravenous medications should be appropriately and safely administered within prevailing medical protocols. If intravenous therapy is for the purpose of hydration, the clinical record shall document any preventive measures and attempts to improve hydration orally, and the individual's inadequate response.]*

6. Respiratory services (1.25 *[hrs/day]* ***hours per day***), which includes the provision of respiratory services *[for]* ***as to*** which the individual is dependent upon licensed nursing staff to administer, such as positive pressure breathing therapy, *[nasal]* Bilevel Positive Airway Pressure (BiPAP) *[or]* ***,*** Continuous Positive Airway Pressure (CPAP) *[and]* ***or*** aerosol therapy. The use of hand***-***held inhalation aerosol devices ***, commonly referred to as "puffers",*** is not included in this add-on service.

7. Head trauma stimulation *[/]* ***; and*** advanced neuromuscular *[/]* ***or*** orthopedic care (1.50 *[hr/day]* ***hours per day***), as follows:

i.-iii. (No change.)

8:85-2.3 Physician services

(a) General requirements for physician services shall be as follows:

1. Each Medicaid beneficiary's care shall be under the supervision of a New Jersey licensed attending physician chosen by, or agreed to by, the Medicaid beneficiary, or if the beneficiary is incompetent, by the family or legal guardian.

2. (No change.)

3. The NF shall maintain arrangements *[which]* ***that*** assure that the services of a New Jersey licensed physician who can act in case of emergency, are continuously available.

(b) Requirements for a medical director shall be as follows:

1. The NF shall retain, pursuant to a written agreement, a physician licensed under New Jersey *[State Law]* ***law*** to serve as Medical Director on a part-time or full-time basis as is appropriate for the needs of the residents and the size of the facility. The Medical Director shall be responsible for the overall development of medical policies and coordination of the medical care in the facility to ensure the adequacy and appropriateness of *[the]* medical services provided to *[the residents]* ***beneficiaries*** and to monitor the health status of *[the]* employees.

i. (No change.)

2. The duties of the medical director shall include, but not be limited to, the following:

i.-xi. (No change.)

xii. Responding quickly and appropriately to medical emergencies *[which]* ***that*** are not handled by another attending physician; and

xiii. Ensuring that, for each Medicaid beneficiary, there is a designated primary and alternate physician who can be contacted when necessary.

(c) Requirements for an attending physician shall be as follows:

1. Initial medical findings and physician's orders;

i. There shall be available to the NF, prior to, or at the time of admission, resident information *[which]* ***that*** includes medical history, diagnosis, current medical findings, medical plan of care and rehabilitation potential.

ii.-iii. (No change.)

2. The attending physician shall also be responsible for initial and ongoing medical evaluation, as follows:

i. The medical assessment of the Medicaid beneficiary shall begin at the time of admission to a NF and shall be the foundation for the planning, implementation, and evaluation of medical services directed toward the care needs of the resident.

ii. The medical assessment shall consist of the complete, documented, and identifiable appraisal (from the time of admission to discharge) of the Medicaid beneficiary's current physical and psychosocial health status. The medical assessment shall be utilized to determine the existing and potential requirements of care. The evaluation of the data obtained from the medical assessment shall lead to the development of the medical services portion of the interdisciplinary care plan. The assessment data shall be available to all staff involved in the care of the resident.

iii. The tools utilized in the assessment process shall include a complete history and physical examination, eliciting medically defined conditions and prior medical history, admission form(s), transfer form(s),

[Health Service Delivery Plan (] HSDP *[)]*, and data from other members of the interdisciplinary team.

iv. Other Medicaid recipient data utilized should include:

(1)-(3) (No change.)

(4) Medical necessity of additional nursing services, in accordance with N.J.A.C. *[10:63]* ***8:85****-2.2;

(5)-(15) (No change.)

v. (No change.)

vi. As an active member of the interdisciplinary team, the attending physician shall:

(1) Identify and document the medical needs of the Medicaid beneficiary;

(2) (No change.)

(3) Be observant of clinical signs and symptoms of the Medicaid beneficiary;

(4) (No change.)

(5) Periodically evaluate and be cognizant of the Medicaid beneficiary's total clinical record including the interdisciplinary care plan and facilitate necessary changes as medically indicated;

(6) Identify and document the effectiveness of, and the Medicaid beneficiary's response to, therapeutic intervention such as medications, treatment and special therapies, and, where possible, the reason for any ineffectiveness in the Medicaid beneficiary's responses.

3. Physician progress notes shall:

i. Be maintained in accordance with accepted professional standards and practices as necessitated by the Medicaid beneficiary's medical condition;

ii. Be a legible, individualized summary of the Medicaid beneficiary's medical status and reflect current medical condition, including clinical signs and symptoms; significant change in physical or mental conditions; response to medications, treatments, and special therapies; indications of injury including the date, time and action taken; medical necessity for extent of change in the medical treatment plan; and

iii. (No change.)

4. (No change.)

5. Physician visits shall be conducted as follows:

i. All required physician visits shall be made by the physician personally, or a physician assistant or nurse practitioner, as permitted by State law.

(1) For the first 90 days, the Medicaid beneficiary shall be visited and examined every 30 days. Thereafter, with written justification, the interval between visits may be extended for up to 60 days.

(2) Additional visits shall be made when significant clinical changes in the Medicaid beneficiary's condition require medical intervention.

8:85-2.4 Rehabilitative services

(a) Rehabilitative services include physical therapy, occupational therapy, and speech-language pathology services provided by a qualified therapist for the purpose of attaining maximum reduction of physical or mental disability and restoration of the resident to his or her best functional level. Rehabilitative services shall be made available to Medicaid beneficiaries as an integral part of an interdisciplinary program. Rehabilitative services shall not

include physical medicine procedures administered directly by a physician, or physical therapy which is purely palliative, such as the application of heat per se, in any form; massage; routine calisthenics or group exercises; assistance in any activity; use of a simple mechanical device; or other services not requiring the special skill of a qualified therapist.

1.-4. (No change.)

8:85-2.5 (No change in text.)

8:85-2.6 Social services

(a)-(h) (No change.)

(i) Social services discharge planning shall be as follows:

1.-3. (No change.)

4. The social worker shall consult the HSDP on admission to determine the recommendations of the professional staff designated by the Department concerning discharge and to identify Track II residents.

5. (No change.)

6. Discharge planning shall be carried out by means of an interdisciplinary care plan that includes goals and time frames. Social work intervention geared towards discharge shall be recorded as interim notes. The discharge plan shall include:

i.-iii. (No change.)

iv. Specific financial assistance needed by the beneficiary; and

v. (No change.)

7.-10. (No change.)

(j) (No change.)

8:85-2.7 Pharmaceutical services; general

(a)-(d) (No change.)

(e) Signed physicians' orders for medications, drugs, tests, diet, and treatment administered to Medicaid beneficiaries must be accurately recorded on the beneficiary's chart with review and update as required.

(f) All services required of a Consultant Pharmacist in NFs, as stipulated in Federal and State statutes, rules and regulations, including, but not limited to, those listed in this subsection shall be provided.

1. Responsibilities of the consultant pharmacist shall be as follows:

i.-iii. (No change.)

iv. Assure that beneficiaries' medication records are accurate, up to date, and that these records indicate that medications are administered in accordance with physician's orders and established stop-order policies;

v. Assure that drugs, biologicals, laboratory tests, special dietary requirements and foods, used or administered concomitantly with other medication to the same beneficiary, are monitored for potential adverse reactions, allergies, drug interactions, contraindications, rationality, drug evaluation, and laboratory test modifications, and that the physician is advised promptly of any recommended changes;

vi. Review the drug regimen (that is, the dosage form, route of administration and time of administration) of each beneficiary at least monthly and prepare a written report of any irregularities pertaining to medications to the attending physician, Medical Director or Director of Nursing, as appropriate. Irregularities in the administration of medications shall also be reported promptly to the Director of Nursing.

vii. Report in writing at least quarterly to the Pharmaceutical Services Committee (Pharmacy and Therapeutics Committee), on the status of the facility's pharmaceutical services and staff performance as related to pharmaceutical services. This report shall include, but not be limited to, a summary of the review of each beneficiary's drug regimen and clinical record and the consultant pharmacist's findings and recommendations;

viii.-xi. (No change.)

8:85-2.8 (No change in text.)

8:85-2.9 Mental health services

(a) All facilities shall assist Medicaid beneficiaries to obtain mental health care through a licensed psychiatrist or psychologist, who shall provide, or make provision for, routine and emergency services.

(b)-(d) (No change.)

8:85-2.10 Dental services

(a) All facilities shall assist Medicaid beneficiaries to obtain dental care though a licensed dentist, who shall provide, or make provision for:

1.-4. (No change.)

(b) Dental examinations carried out to comply with the Department of Health and Senior Services' minimal requirements, as defined in N.J.A.C. 8:39-15.1, as well as regular dental examinations, shall not be considered consultations and need not be brought to the attending physician's attention except as a matter of courtesy. However, treatments which involve invasive procedures such as extractions or fillings, except in an emergency, shall be brought to the attention of the attending physician who acknowledges clearance for such treatment on the order sheet.

(c)-(e) (No change.)

8:85-2.11 Podiatry services

(a) All facilities shall assist Medicaid beneficiaries to obtain podiatry care through a licensed podiatrist who shall provide, or make provision for:

1.-4. (No change.)

(b)-(c) (No change.)

8:85-2.12 Chiropractic services

All facilities shall assist Medicaid beneficiaries to obtain chiropractic care through a licensed chiropractor who shall provide, or make provision for, routine and emergency services.

8:85-2.13 Vision care services

(a) All facilities shall assist Medicaid beneficiaries to obtain vision care through a licensed ophthalmologist or optometrist who shall provide, or make provision for, routine and emergency services.

(b) (No change.)

8:85-2.14 Laboratory; X-ray, portable X-ray and other diagnostic services

(a) A NF shall have written agreements with one or more general hospitals or one or more clinical laboratories so that the facility can obtain laboratory services, including emergency services promptly. If the facility has its own laboratory capabilities, the services may not be billed on a separate fee-for-service basis. A laboratory must be:

1. Licensed and/or approved by the New Jersey State Department of Health and Senior Services and the State Board of Medical Examiners, which includes meeting Certificate of Need and licensure requirements, when required, and all applicable laboratory provisions of the New Jersey Sanitary Code; and

2.-3. (No change.)

(b) (No change.)

(c) A NF shall have written agreements with one or more general hospitals or one or more qualified providers so that the facility can obtain other diagnostic services, such as ECG, EEG, CAT scan, MRI and ultrasonogram, including emergency services, promptly.

1. (No change.)

2. All findings and reports shall be recorded in the beneficiary's clinical record.

8:85-2.15 Medical supplies and equipment

(a)-(b) (No change.)

(c) Routinely used durable medical equipment ordered for Medicaid beneficiaries in a participating NF (for example, walkers, wheelchairs, bed-rails, crutches, traction apparatus, intermittent positive-pressure breathing (IPPB) machine, electric nebulizers, electric aspirators, low-end pressure relief systems such as mattress overlays and mattress replacements, powered mattress systems and powered flotation beds) and other therapeutic equipment and supplies essential to furnish the services offered by the facility for the care and treatment of its residents shall be considered part of the NF's cost, and shall not be billed directly to the program by the supplier.

(d) When unusual circumstances require special medical equipment not usually found in a NF, such special equipment may be reimbursable, with prior authorization from the Medical Assistance Customer Center (MACC) serving the county where the facility is located.

1. When special medical equipment is authorized and purchased on behalf of a Medicaid beneficiary, ownership of such equipment shall vest in the Division of Medical Assistance and Health Services (DMAHS). The beneficiary shall be granted a possessory interest for as long as the beneficiary requires use of the equipment. When the beneficiary no longer needs such equipment, possession and control shall revert to DMAHS. The beneficiary shall agree to this when he or she signs the "patient's certification" section on the claim form. The NF shall notify the MACC in writing when such equipment is no longer in use.

2. Prior authorization requests for special medical equipment shall be accompanied by documentation from the attending physician, the registered professional nurse who has primary responsibility for the beneficiary, and appropriate rehabilitative therapy personnel, which relates the medical necessity for the equipment and describes the extraordinary requirements of the beneficiary.

3. Pressure relief systems shall be reimbursed in a NF under the following conditions:

   i. Air Fluidized and Low Air Loss therapy beds, as defined in N.J.A.C. 8:85-1.2, shall be considered special medical equipment and shall be prior authorized for reimbursement in a NF only when all of the following criteria, indicating medical necessity, are documented by the physician.

      (1) The beneficiary has two stage III (full-thickness tissue loss) pressure sores or a stage IV (deep tissue destruction) pressure sore which involves two of the following sites: hips, buttocks, sacrum.

      (2) The beneficiary with coexisting risk factors (such as vascular irregularities, nutritional depletion, diabetes or immune suppression) presents post-operatively with a posterior or lateral flap or graft site requiring short-term therapy until the operative site is viable.

(3) The beneficiary is bedridden or chair-bound as a result of severely limited mobility.

(4) The beneficiary is receiving maximal medical/nursing care, prior instituted conservative treatment has been unsuccessful and all other alternative equipment has been considered and ruled out.

(5) The bed is ordered, in writing, by the attending physician based on his or her comprehensive assessment (which includes a physical examination) and evaluation of the beneficiary.

(6) (No change.)

ii. (No change.)

iii. Prior authorization of air fluidized or low air loss therapy beds, if approved, shall be granted for 30 days only. Continued use beyond the initial approval period shall require prior authorization on a monthly basis. The following information shall be submitted to the MACC to obtain prior authorization:

(1)-(7) (No change.)

(8) Photographs of the site upon permission of the beneficiary/family, after full due consideration is afforded to the beneficiary's right to privacy, dignity and confidentiality.

iv. After treatment with an air fluidized or low air loss therapy bed is initiated, the beneficiary shall:

(1) (No change.)

(2) Remain on the therapy unit and be confined to bed, unless medically necessary. While confined to bed, due consideration shall be given to the beneficiary's need for social and sensory stimulation and recreational diversion by providing in-room visitation and social/recreational activities appropriate to the beneficiary's condition; and

(3) (No change.)

v. Professional staff from the MACC may, at their discretion, perform an onsite visit to evaluate the beneficiary prior to or after therapy has been instituted. Continued approval shall be contingent

upon the facility's compliance with the criteria and conditions defined in (d)3i, ii, iii and iv above and cooperation of the beneficiary to the therapeutic modality.

8:85-2.16 (No change in text.)

8:85-2.17 Transportation services

(a) The NF shall assist a Medicaid beneficiary in obtaining transportation when the beneficiary requires a Medicaid-covered service or care not regularly provided by the NF.

(b)-(c) (No change.)

(d) Invalid coach services shall not require prior authorization from the MACC.

1. (No change.)
2. An invalid coach may be utilized when a Medicaid beneficiary requires transportation from place to place for the purpose of obtaining a Medicaid-covered service and when the use of an alternative mode of transportation, such as a taxi, bus, livery, or private vehicle, would create a serious risk to life or health.

(e) Transportation by taxi, train, bus and other public conveyances shall not be directly reimbursable by the New Jersey Medicaid program. Inquiry should be made to the County Welfare Agency (CWA) for authorization and payment for such transportation.

(f) (No change.)

8:85-2.18 Bed and board

(a) Beds are provided in rooms licensed by the New Jersey Department of Health and Senior Services. A NF providing care to children shall have available protective cribs for infants and small children, as well as appropriate furniture, sized and scaled for children.

(b) (No change.)

8:85-2.19 (No change in text.)

8:85-2.20 Non-covered services

(a) Medicaid beneficiaries residing in NFs shall not be eligible to receive Medicaid reimbursement for the following services:

1.-4. (No change.)

5. Practitioner or therapy services furnished on a fee-for-service basis by an owner, partner, administrator, stockholder, or others having direct or indirect financial interested in the NF;

6. Partial care services in independent clinics; or

7. Medical/social day care.

8:85-2.21 Special care nursing facility (SCNF)

(a) A special care nursing facility (SCNF) is a nursing facility or separate and distinct SCNF unit within a Medicaid-certified conventional nursing facility which has been approved by the Department of Health and Senior Services to provide care to New Jersey Medicaid beneficiaries who require intensive nursing facility services beyond the scope of a conventional nursing facility as defined in N.J.A.C. 8:85-2. A SCNF or SCNF unit shall have a minimum of 24 beds.

1. The minimum bed requirement will be waived for SCNFs that were approved by DMAHS prior to November 23, 1994. In addition, the requirement will be waived in those instances where a SCNF's Certificate of Need stipulates a specific number of beds approved by the New Jersey Department of Health and Senior Services.

2. A SCNF receiving reimbursement through the Medicaid program shall not increase its total number of licensed beds for which a SCNF rate of reimbursement is received except upon approval from the Department.

3. A SCNF shall provide intensive medical, nursing and psychosocial management to the seriously ill individual who has potential for measurable and consistent maturation or rehabilitation, or has a technologically and/or therapeutically complex condition which requires the delivery of intensive and coordinated health care services on a 24-hour basis.

(b) A SCNF shall provide the services of an interdisciplinary team, under the direction of a physician specialist, who has training and expertise in the treatment specific to the medical condition and needs of the target population.

1. Within a focused therapeutic program, targeted, when appropriate, at timely discharge to alternative health care settings, such as conventional NF or community-based services, the SCNF shall provide:

i.-iii. (No change.)

(c) A SCNF shall provide services to Medicaid beneficiaries who have been determined, through the PAS process, to require extended rehabilitation and/or complex care. The individual's progress and overall response to the therapeutic regimen shall determine length of stay.

1. (No change.)

2. Complex care shall be considered for a medically stable individual judged to have plateaued who demonstrates the need for prolonged, technologically and/or therapeutically complex care. Although the rehabilitative component may be less intense, the individual continues to require focused assessment, coordinated care planning and direct services on a continuing basis provided by an interdisciplinary team with training and expertise in the treatment of the medical conditions and specialized needs of the resident population. The individual may remain for a period of up to two years with review every 12 months. Length of stay will be extended for periods of six months if continued benefit from the service can be demonstrated.

3. Medicaid beneficiaries who are suitably placed in the community, receiving care in appropriate alternative placements or referred for social reasons only shall not be authorized for admission to a SCNF.

(d) Discharge procedures shall include utilizing Medicaid discharge protocols established by this chapter, and shall be in accordance with the following:

1. The beneficiary shall be discharged upon achievement of maximum benefit from the specialized programming and maximum level of functioning and when the individual's condition can be appropriately managed in either the community or other forms of institutional care.

2. (No change.)

3. When a beneficiary residing in a SCNF unit of a conventional NF is determined by Department staff to no longer require special programming, yet continues to require conventional NF services, the beneficiary shall be accepted for placement into a conventional NF bed in the facility. If a conventional NF bed within the facility is not available within a reasonable time, the SCNF shall assist the individual in finding placement in another conventional nursing facility. The SCNF shall be afforded 30 to 60 days from the date of the determination to effect transfer of the beneficiary to a bed within the facility's conventional bed allocation or arrange transfer to another conventional NF.

(e) The SCNF shall provide all required services, as defined in this subchapter.

1. A SCNF shall provide those medical services as defined in N.J.A.C. 8:85-2.3, with the following modifications and/or additions:

i. A freestanding SCNF shall have a designated medical director who is board eligible/certified in a medical specialty as targeted by the medical diagnoses, medical conditions and/or resident population of the SCNF. The medical director shall also function as a primary care attending physician. If a medical group provides medical services, a member of that group shall be designated as the medical director.

(1) In lieu of the requirements contained in (e)1i above, a freestanding SCNF may have a designated medical director who is a licensed physician and was serving as medical director prior to November 23, 1994.

ii. For each resident there shall be a designated primary care physician specialist who is board eligible/certified in a medical specialty determined by the medical diagnoses, medical conditions and or resident population;

iii. (No change.)

2. A SCNF shall provide those nursing services as defined in N.J.A.C. 8:85-2.2 with the following modifications and/or additions:

i. A freestanding SCNF shall have a director of nurses or a nursing administrator who is a registered professional nurse in the State of New Jersey and possesses a Master's Degree or a Baccalaureate Degree in Nursing and has a minimum of two years experience as a nursing administrator or who has at least two years of supervisory experience in either an acute or long-term care setting.

(1) In lieu of the education and experience requirements of (e)2i above, the director of nurses or nursing administrator shall have served in that capacity prior to November 23, 1994.

(2) A SCNF unit within a conventional NF whose director of nursing does not meet the qualifications of (e)2i above shall have a nurse manager who meets the qualifications assigned full time to the unit.

ii. (No change.)

iii. Two and one-half hours of basic nursing services by registered professional nurses, licensed practical nurses and certified nurse aides as defined in N.J.A.C. 8:85-2.2 shall be provided per beneficiary per day. Additional nursing services in a SCNF up to a maximum of three hours may be provided due to technically complex nursing needs and/or intensive rehabilitative/restorative nursing care needs. A SCNF which is an identifiable unit within a conventional NF shall calculate the nurse staffing level separate and apart from the nurse staffing level of the conventional beds.

iv. Provision of additional nursing services *[(acuities)]* as defined in N.J.A.C. 8:85-2.2 does not apply to nurse staffing rules in a SCNF. The additional nursing

services *[(acuities)]* described at N.J.A.C. 8:85-2.2(a) are included in the three hours.

(1) (No change.)

v. (No change.)

3. A SCNF shall provide those social services as required by N.J.A.C. 8:85-2.6, with the following modifications and/or additions:

i.-iii. (No change.)

iv. Responsibilities of the social service staff, in concert with other members of the interdisciplinary team, include, but are not limited to:

(1)-(3) (No change.)

(4) Coordinate programming with community-based resources to facilitate continuity of care and assimilation into community/family environment.

(5) (No change.)

4. A SCNF shall provide resident activities required by N.J.A.C. 8:85-2.5, with the following modifications and/or additions:

i. The director of resident activities shall possess a Master's Degree or Baccalaureate Degree from an accredited college or university with a major area of concentration in recreation, creative arts therapy, occupational therapy or therapeutic recreation. In addition, three years of experience in a clinical, residential or community-based therapeutic recreation program is required.

(1) In lieu of (e)4i above, the individual shall have served as director of resident activities prior to November 23,1994; or

(2) (No change.)

ii.-iv. (No change.)

5. A SCNF shall provide, directly in the facility, the rehabilitation services as required by N.J.A.C. 8:85-2.4 on an intensive level which are specifically targeted to meet the goals of the prescribed treatment plan.

i.-ii. (No change.)

6. Mental health services provided by a licensed psychiatrist, psychologist or other appropriately credentialed professional shall be provided to residents with mental health disorders in accordance with N.J.A.C. 8:85-2.9.

7. A SCNF that provides ventilator management of New Jersey Medicaid eligible children or adults shall provide respiratory therapy services beyond the scope of N.J.A.C. 8:85-2, which shall include, but not be limited to:

i.-iii. (No change.)

iv. Medically prescribed respiratory therapy may be provided to non-ventilator dependent children or adults who, due to cardio-respiratory deficiencies and/or abnormalities, require:

(1)-(5) (No change.)

(6) Drawing and analyzing samples of arterial, capillary and venous blood;

(7) Administration of aerosolized respiratory medications such as nebulized bronchodilators or antiprotozoals;

(8) Assessment, intervention, and evaluation by a registered professional nurse; and/or

(9) Protocols for weaning the individual from assisted respiration and/or self care when

clinically indicated and ordered by the physician or advanced practice nurse.

SUBCHAPTER 3. COST REPORT, RATE REVIEW GUIDELINES AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

8:85-3.1 Purpose and scope

(a) These rules describe the methodology to be used by the State of New Jersey, Department of Health and Senior Services (Department), to establish prospective per diem rates for the provision of nursing facility services to residents under the State's Medicaid program.

(b) The Department believes that the strict application of these rules will generally produce equitable rates for the payment of nursing facilities (NFs) for the reasonable cost of providing routine patient care services. The Department recognizes, however, that no rules can be developed which might not result in some inequities if applied rigidly and indiscriminately in all situations. Inequities could be in the form of rates that are unduly low or rates that are unduly high.

(c) Accordingly, in the case where a NF believes that, owing to an unusual situation, the application of these rules results in an inequity, the Department is prepared to review the particular circumstances with the NF. Appeals on the grounds of inequity should be limited to circumstances peculiar to the NF affected. They should not address the broader aspects of the rules themselves.

(d) On the other hand, these rules are not purported to be an exhaustive list of unreasonable costs. Accordingly, notwithstanding any inference one may derive from these guidelines, the Department reserves the right to question and exclude any unreasonable costs, consistent with the provision of N.J.S.A. 30:4D-1 et seq.

(e)-(f) (No change.)

8:85-3.2 Cost report preparation and timing of submission

(a) Nursing facilities shall furnish required cost reports to the Department of Health and Senior Services, Office of Nursing Facility Rate Setting and Reimbursement, within 90 days of the close of each fiscal year. For the purpose of this subchapter, the period for which these actual data are reported will constitute the "base period" for establishing prospective per diem reimbursement rates commencing six months after the end of the base period. These rates will not be subject to routine retroactive adjustments except for matters specified in this subchapter. As required by Federal regulations at 42

CFR 447.304, prospectively determined payment rates will be redetermined at least annually.

(b)-(c) (No change.)

(d) The Assistant Commissioner, Division of Senior Benefits and Utilization Management, or a designee of the Assistant Commissioner, may mitigate or waive the penalties specified in (b) above, for "good cause" shown:

1.-2. (No change.)

3. All requests for mitigation and/or waiver of the penalty provisions must be submitted in writing, and accompanied by such documentation and/or supporting affidavits as the Assistant Commissioner may require.

(e) The penalty rates indicated in (b) above will be applied to cost reports commencing with the reporting periods ending May 31, 1980.

(f) A nursing facility cost report cannot be substituted or revised by a NF except during the 30 calendar days after the original due date of the cost report to the Department of Health and Senior Services, Nursing Facility Rate Setting and Reimbursement. However, such substitution or revision can be made if it would prevent an overpayment to the NF.

8:85-3.3 Rate components

(a) The prospective rates will be "screened" rates per day calculated by applying standards and reasonableness criteria ("screens") for three classes of NFs:

1. (No change.)

2. Class II Governmental NFs:

   i. To qualify as a Class II Governmental NF, the NF shall meet all of the contractual requirements of the Department of Health and Senior Services and be a governmental operation.

3. Class III (Special Care) Nursing Facilities (SCNFs).

   i. To qualify as a SCNF, the NF must meet all of the contractual requirements and be approved by the Department as a SCNF.

   ii. SCNFs shall be grouped by :

   (1)-(6) (No change.)

(b)-(c) (No change)

1.-3. (No change)

(d) The development of the "screens" for Class I, Class II, and Class III NFs includes the governmental NFs' and SCNFs' reported costs and statistics in the following areas:

1.-3. (No change.)

(e)-(f) (No change.)

(g) A provision for inflation will be added to reasonable base period costs in calculating the prospective rates as described in N.J.A.C. 8:85-3.19.

(h)-(k) (No change.)

8:85-3.4 (No change in text.)

8:85-3.5 Raw food costs

(a) Raw food costs per patient day for voluntary and proprietary NFs which provide their own food service and which had over 20 percent Medicaid patient days in the base period will be determined. NFs that contract for their dietary operations will be excluded. These per diem costs will be ranked in descending order on a Statewide basis. The reasonableness limit will be set at 120 percent of the median cost per day.

1.-2. (No change.)

(b) For NFs below this limit, prospective rates will be based upon actual costs. Where homes report unit costs 15 percent or more below the median, the Department will inspect the food operations for compliance with State standards.

(c) (No change.)

8:85-3.6 General services expenses

(a) (No change.)

(b) The bases for screen development and reported costs subject to applicable screens are as follows:

1. Food: As indicated in N.J.A.C. 8:85-3.5.

2.-4. (No change.)

(c) (No change.)

8:85-3.7 Property operating expenses

(a) Property operating expenses include property taxes and utilities.

1. (No change.)

2. For this purpose, reasonable plant square feet (and related property taxes) are determined as follows:

   i.-ii. (No change.)

   iii. The reasonableness limit for each NF's plant square feet shall be established at 110 percent of the base for its licensed beds. (See N.J.A.C. 8:85-3.11 for NFs with residential or sheltered care patients).

3. For NFs whose plant square feet exceeds this limit, the property taxes related to the excess will be excluded from the rate base. For this purpose, it will be assumed that assessed values for buildings vary directly in relation to their areas. The latitude set forth in (a)2iii above is intended to provide for inequities that could result from this assumption. The Department will review, on an individual basis, any additional inequities which owners believe are brought about by unusual circumstances.

4. For NFs whose appraised value per plant square foot (as determined by an agent designated by the State) is greater than 110 percent of the median construction costs at 1977 price levels, the property taxes attributable to the excess will be excluded from the rate base unless the owners can demonstrate unusual circumstances. For screening new NFs, this figure will be revised each year for inflation and for effects of standards changes upon construction cost. (See N.J.A.C. 8:85-3.11 for the methodology for calculating this limit at 1977 price levels.)

5.-6. (No change.)

7. After making any adjustments per (a)6 above, taxes based upon land appraisals in excess of 140 percent of the median appraisal value of five acres, rural, and two acres, urban, of all NFs in the county will also be considered unreasonable. In the case of counties with fewer than five NFs, neighboring counties may be combined in determining the median value to be used.

8. (No change.)

(b) (No change.)

(c) Utility costs will be screened for reasonableness as follows:

1. Base period utility costs per bed will be deemed unreasonable to the extent that they exceed 125 percent of the Statewide median cost per bed, as determined for each class type of NF indicated in N.J.A.C. 8:85-3.3.

i. (No change.)

8:85-3.8 Special amortization

(a) The Department will consider on an individual basis, the amortization of start-up costs and special expenditures in rates. Each case will be reviewed on its particular merits and, accordingly, no guidelines are specified herein. As a rule, however, provisions for special amortization would relate to expenditures of a capital nature that are mandated by changes in law and regulations. The amortization period would generally range from 12 to 60 months, depending upon the nature and magnitude of expenses.

(b) In approving the amortization of special expenditures, the Department will also consider the extent to which a NF's rates are based on capital and cost levels of fully complying NFs, or, for capital items, a review of a minimum of three bids on the acquisition or project.

8:85-3.9 Routine patient care expenses

(a) (No change.)

(b) Reasonableness limits for nursing services (RNs, LPNs and other) will be established as follows:

1. The minimum nursing requirements in terms of hours worked will be calculated for each Class I and Class II NF based upon:

i. The number of patient days reported on the cost report during the base period;

ii. The minimum nurse staffing standards of 2.5 hours/day in accordance with N.J.A.C. 8:39-25 during the base period; and

iii. The total number of residents reported on the cost report that were receiving additional nursing services as based on the following *[acuities]* ***services as more fully described at N.J.A.C. 8:85-2.2(f),*** during the base period:

Wound care	0.75 hour*[s/]* ***per*** day
[Nasogastric tube] ***Tube*** feeding*[s and/or gastrostomy]*	1.00 hour*[s/]* ***per*** day
Oxygen ***therapy***	0.75 hour*[s/]* ***per*** day
Tracheostomy	1.25 hours *[/]* ***per*** day
Intravenous therapy	1.50 hour***s*** *[/]* ***per*** day
Respiratory services	1.25 hour***s*** *[/]* ***per*** day
Head trauma stimulation *[/]* ***; and*** advanced neuromuscular*[/]* ***or*** orthopedic care	1.50 hour***s*** *[/]* ***per*** day

(1) The month of onset of additional nursing services should be counted as one full month, whether the services are continued or discontinued before the end of the month. After the first month, count the patient only if the additional services are being provided at the end of the next month. If the need for additional nursing services ceases during the month following the month of onset, that month is not counted. However, as stated above, the month of onset is counted as one full month.

(2) If the patient, who requires additional nursing services, dies in the same month as the onset of the services, the patient is counted.

(3) Count the patient requiring additional nursing services if they are on 10-day bed hold or therapeutic leave at the end of the calendar

month as though they are still in the facility. If the patient requiring additional nursing services is on bed hold or therapeutic leave in one calendar month and it extends into the following month, and the patient either does not return to the same facility or goes beyond the bed hold allowance through that following month, the additional nursing services are not counted in that following month. When the same patient requiring additional services returns to the same facility or another facility, the additional nursing services are counted in the readmission/admission calendar month, provided the need for additional nursing services persists through that calendar month.

iv. (No change.)

2.-4. (No change.)

5. The average equalized hourly compensation rate of each type of nurse (see N.J.A.C. 8:85-3.4) will be calculated separately for Class I, Class II, and each type of Class III facility.

i. (No change.)

6.-7. (No change.)

(c) (No change.)

(d) Reasonableness limits for medical supplies and patient activities will be established at:

1.-2. (No change.)

3. 150 percent of the median per diem cost for each type of Class III NF, excluding any facility without reported costs.

i. For Class III NFs which are approved as a combination of Ventilator/Respirator type and some other SCNF type listed at N.J.A.C. 8:85-3.3(a)3ii, the reasonable limit for medical supplies will be determined by multiplying applicable patient days (ventilator patient days versus a non-Ventilator/Respirator SCNF-type patient days) times the appropriate medical supplies screen (ventilator versus a non-ventilator/respirator SCNF type) and adding the products, as follows:

	(1)	(2)	(3)
	Base period	Limit	Total
	Patient Days	Per day	(1) x (2)
Vent	A	C	E
Other	B	D	F
Total reasonable limit (E + F)			G

(e) Reasonableness limits for medical director, pharmaceutical consultant, non-legend drugs, social services and oxygen will be established at:

1.-2. (No change.)

3. 110 percent of the median per diem cost for each type of Class III NF, excluding any facility without reported costs, except as provided in (e)3i and ii below:

i. (No change.)

ii. For Class III NFs which are approved as a combination of a Ventilator/Respirator type and some other SCNF type listed at N.J.A.C. 8:85-3.3(a)3, reasonable limits for oxygen will be determined by multiplying applicable patient days (ventilator patient days versus a non-ventilator/respirator SCNF type patient days) times the appropriate oxygen screen (ventilator versus a non-ventilator/respirator type SCNF) and adding the products, as follows:

	(1)	(2)	(3)

	Base period	Limit	Total
	Patient Days	Per day	(1) x (2)
Vent	A	C	E
Other	B	D	F
Total reasonable limit (E + F)			G

(f) Where actual base period costs for routine patient care are below the limits established, the actual costs will be included in the rate base. The Department of Health and Senior Services, Long Term Care Assessment and Survey as authorized at N.J.A.C. 8:39, will be notified of all cases where NF patient care costs per day are less than 75 percent of the respective limit in N.J.A.C. 8:85-3.5 and 3.9 and in each case where nursing hours worked appear to be below the State standards.

8:85-3.10 Property-capital costs

(a) (No change.)

(b) The rules promulgated herein have been developed with the following objectives and considerations:

1. The Department should not concern itself with the method and attendant costs with which individual NFs are financed and constructed or the arrangements under which they are acquired or leased.
2. While not concerning itself about the costs, financing and so forth, of individual NFs, the Department's mandate with respect to the reasonableness of cost requires it to develop this rate component upon the presumption of reasonable facility costs and prudent financing.
3. (No change.)

(c) The Department believes that the above objectives can best be met by establishing an aggregate "capital facilities allowance" (CFA). The aggregate annual CFA for building, land, and movable equipment shall constitute the maximum reasonable reimbursement for depreciation (except automobiles), rentals of buildings and equipment (except automobiles), interest on all indebtedness, and amortization of leasehold improvements. Reimbursement shall be limited to the lower of:

1.-2. (No change.)

(d) The following considerations will be addressed in determining the CFA:

1. Buildings (see N.J.A.C. 8:85-3.11);

2. Land and land improvements (see N.J.A.C. 8:85-3.12);

3. Equipment (routine moveable) (see N.J.A.C. 8:85-3.13);

4. Maintenance and replacements (see N.J.A.C. 8:85-3.14);

5. Property insurance (see N.J.A.C. 8:85-3.15);

6. Economic occupancy level (see N.J.A.C. 8:85-3.16).

8:85-3.11 (No change in text.)

8:85-3.12 Land

(a) The CFA for land will be based upon appraised value of land and land improvements determined by an agent designated by the State of New Jersey as follows:

1.-5. (No change.)

6. The Department shall establish a reasonableness limit on the amount of reimbursement that an NF shall receive for the land component of its CFA. Reasonableness limits for land and land improvements will be the same as defined for property taxes on land at N.J.A.C. 8:85-3.7.

i.-ii. (No change.)

iii. For acquisitions of land related to addition(s) to building or building replacements (see N.J.A.C. *[10:63]* ***8:85***-1.2 for definition of "replacement

nursing facility"), a single weighted reasonableness limit for the entire NF land evaluation shall be calculated based upon acreage and the appraisal land limit factors of land as originally appraised and the land-appraised addition(s) to land.

(b) The applicable interest rate developed for a facility per N.J.A.C. *[10:63]* ***8:85****-3.11(f) will be applied to the reasonable appraised land value.

(c) The provisions of N.J.A.C. *[10:63]* ***8:85****-3.11(l) and (m) will also apply to CFA for land.

(d) (No change.)

8:85-3.13 Moveable equipment

(a) (No change.)

(b) The allowance per licensed bed will be determined by applying to this median cost the applicable interest rate developed per N.J.A.C. 8:85-3.11(f).

(c) Inasmuch as this allowance will be based upon the current replacement cost of new equipment, it will be deemed to provide for unusually large expenditures for maintaining old equipment (the Department considers it to be purely a management prerogative as to when to replace, rather than repair, old equipment). *[Effective with rates implemented on or after July 1, 2000, a]* ***A**** provision for ongoing routine equipment maintenance and replacements will *[not]* be included in the maintenance and replacements allowance as described in N.J.A.C. 8:85-3.14.

8:85-3.14 Maintenance and replacements

(a) An allowance for the maintenance of land, land improvements, building and building equipment and for replacement of building equipment will be developed for Class I and Class II facilities and each type of Class III facility as follows:

1.-5. (No change.)

6. Each NF's maximum total allowance per reasonable plant square foot for any one year will be developed by applying this formula to its particular factors and incrementing the result by 10 percent. No allowance will be provided for plant square feet considered unreasonable per N.J.A.C. 8:85-3.7(a)1, 2 and 3.

i. For Class III NFs which are approved as a combination of Ventilator/Respirator type and some other SCNF type listed at N.J.A.C. 8:85-3.3(a)3ii, the reasonable limit for maintenance and replacements will be determined by multiplying the current costs of maintenance and replacement attributable to each type of SCNF patient times the respective cost per square foot maintenance and replacement cost limits. The products will be totaled, and then divided by the total current cost of maintenance and replacement expenses. The resulting combined cost limit will then be multiplied by the reasonable long term care square feet of the SCNF to determine the maintenance and replacement screen.

	(1)	(2) Limit Per	(3) Total
	Cost	square foot	(1) x (2)
Vent	A	C	E
Other	B	D	F
	G		H

Weighted limit per square foot = H/G

Total reasonable limit = Weighted limit x Square feet

7.-8. (No change.)

8:85-3.15 Property insurance

(a) An allowance for property insurance will be developed for each home as follows:

1.-2. (No change.)

3. The procedures described in N.J.A.C. 8:85-3.14 will be used to eliminate extremes and to develop the formula to be used to calculate the reasonableness limit for property insurance, except for the calculation of Class III limits.

4. Each NF's reasonableness limit per reasonable plant square foot will be developed by applying this formula to its particular factors and incrementing the result by 10 percent. No allowance will be provided for plant square feet considered unreasonable per N.J.A.C. 8:85-3.7(a)1 and 2.

8:85-3.16 Target occupancy levels

(a) A target occupancy level of 95 percent of licensed bed-days (excluding quiet beds) will be used to develop the reasonable per diem amounts for the following rate components:

1.-4. (No change.)

5. Actual NF expenses for depreciation, rental, interest, and amortization in accordance with N.J.A.C. *[10:63]* ***8:85***-3.10(c).

(b)-(f) (No change.)

8:85-3.17 (No change in text.)

8:85-3.18 Adjustments to base period data

(a) As described elsewhere in this subchapter, with the exception of capital items, rates will be based upon reasonable actual base period costs. This section provides for adjustments to reasonable base period costs in establishing prospective rates.

1.-2. (No change.)

3. With respect to requests for management changes, the Department will take the position that it is not a prerogative of a rate setting body to unilaterally make or amend social policies, especially with respect to the appropriateness of current allocations of State resources to the care of indigent NF patients. Accordingly, in the absence of other compelling reasons, management changes will be approved only in areas where quality has been found to be marginal by health facility inspection and actual costs are commensurately low.

4. (No change.)

5. In the case of significant items, the Department may exclude the effects of legal and management changes from rates until the change is effected, and, if necessary, new appraisals made.

8:85-3.19 Inflation

(a) (No change.)

(b) This inflation factor will be developed by the Department.

(c)-(e) (No change.)

(f) No provision for inflation will be made with respect to costs for buildings, land, moveable equipment, interest and lease, as determined by N.J.A.C. 8:85-3.11, 3.12 and 3.13 nor to special amortization of capital costs as determined by N.J.A.C. 8:85-3.8.

8:85-3.20 (No change in text.)

8:85-3.21 Appeals process

(a) When a NF believes that, owing to an unusual situation, the application of these rules results in an inequity (except for the application of N.J.A.C. 8:85-3.2(f)), two levels of appeals are available: a Level I *[Appeal]* ***appeal*** heard by representatives *[from]* ***of*** the Department *[of Health and Senior Services]*; and a Level II *[Appeal]* ***appeal*** heard before an Administrative Law Judge.

1. *[Level I Appeal:]* A request for a Level I appeal should be submitted in writing to the Department of Health and Senior Services, Nursing Facility Rate Setting and Reimbursement, *[P.O.]* ***PO*** Box 715 ***,*** Trenton, *[New Jersey]* ***NJ***, 08625***-0715***.

   i. Requests for Level I appeals shall be submitted in writing within 60 days of the receipt of notification of the rate by the facility and shall include as follows:

      (1) A letter requesting a Level I appeal from the facility and/or from the facility's designated representative;

      (2) A specific description of each appeal issue; and

(3) Appropriate documentation that will be sufficient for the Department to understand the nature of each issue of the appeal. No issues other than the specific issues identified in the original Level I appeal shall be heard at the Level II hearing.

ii. Adjustments resulting from the Level I appeal submitted in accordance with (a)1i above shall be effective as follows:

(1) At the beginning of the prospective reimbursement period if either an error in computation was made by the Department or the appeal was submitted within the specified period.

(2) On the first day of the month following the date of appeal for non-computational matters if the appeal is submitted after the specified period.

iii. The date of submission shall be defined as the date received by the Department of Health and Senior Services.

2. *[Level II Appeal (Administrative Law Appeal):]* If the NF is not satisfied with the results of the Level I *[Appeal]* ***appeal***, *[It]* ***the NF*** may request a hearing before an Administrative Law Judge. No issues other than the specific issues identified in the original Level I appeal shall be heard at the Level II hearing.

i. Request for an administrative hearing must be submitted in writing to the *[New Jersey State]* Department of Health and Senior Services, *[Health Facilities]* Nursing Facility Rate Setting and Reimbursement, *[P.O.]* ***PO*** Box 715, Trenton, *[New Jersey]* ***NJ*** 08625***-0715***.

ii. Requests for an Administrative hearing will be considered timely filed if they are submitted within 20 days from the mailing of the ruling in the Level 1 appeal.

iii. (No change.)

iv. At the *[Administrative]* ***Level II*** hearing***,*** the burden is upon the NF to demonstrate entitlement to cost adjustments under CARE Guidelines (Cost Accounting and Rate Evaluation System). A complete

set of CARE Guidelines may be obtained from: New Jersey State Department of Health and Senior Services, Nursing Facility Rate Setting and Reimbursement, *[P.O.]* ***PO*** Box 715, Trenton, *[New Jersey]* ***NJ*** 08625***-0715***.

***[10:63-3.25]* *8:85-3.22 Transfer of ownership**

(a) The following applies to the transfer of ownership of a nursing facility, as defined in N.J.A.C. *[10:63]* ***8:85***-1.2:

1. (No change.)
2. For any facility that transfers ownership, the maintenance and replacement carryunder or carryover shall not be applicable to the new owner. After a first year of actual costs are incurred by the new owner, a maintenance and replacement carryunder or carryover shall be calculated based on N.J.A.C. *[10:63]* ***8:85***-3.14(a)7i.

SUBCHAPTER 4 AUDIT

8:85-4.1 Audit cycle

(a) Any cost report submitted by a Medicaid participating nursing facility (NF) which is selected for audit on or after February 7, 1983 may be audited within three years of the due date of the cost report or the date it is filed, whichever is later. This requirement shall be satisfied if the on-site audit of the NF is initiated within the three-year period and completed within a reasonable time thereafter. If a NF audit is not initiated within this time limit, the appropriate cost report or cost reports shall be excluded from the audit, subject to the conditions set forth in the balance of this subsection and the waiver provisions set forth in (b) below. Exclusion is subject to the following conditions:

1. Failure to initiate a timely audit shall not preclude the Department from collecting overpayments, interest or other penalties if the overpayments are identified by an agency other than the Department.
2. When a timely audit is conducted and additional overpayments are discovered by another agency, the Department shall not be precluded from collecting such overpayments together with any applicable interest or other penalties.

(b) The Department shall not be precluded from waiving the three-year limitation for good cause, and good cause shall include, but not be limited to, the following circumstances:

1.-2. (No change.)

3. The Department could not have reasonably discovered by audit any evidence of the overpayment within the three-year period;

4. (No change.)

(c) Notice must be given to the NF when the three year requirement is waived together with the reasons for such action. The NF may request a hearing on any waiver by the Department to the extent authorized by applicable statutes, rules and regulations.

8:85-4.2 Audits

(a) For the exclusive purpose of calculating interest, under N.J.S.A. 30:4D-17(f), "completion of the field audit" for nursing facility providers shall be defined in the following manner:

1. (No change.)

2. For all such audits and audit recovery cases pending on March 1, 1983, which are, have been or will be referred either to the Legal Action Committee, or to the Division of Criminal Justice or other agency for criminal investigation, it shall mean the date the Division of Medical Assistance and Health Services (DMAHS), Office of Program Integrity Administration (OPIA), receives authorization to take administrative action.

3. (No change.)

(b)-(d) (No change.)

8:85-4.3 Final audited rate calculation

(a) The Department will calculate final per diem rates based on audit adjustment reports.

(b)-(c) (No change.)

(d) The basis for establishing guidelines for the prospective per diem rates, and costs which may be reported, are the CARE (Cost Accounting and Rate Evaluation System) Guidelines which appear at N.J.A.C. 8:85-3.

(e) (No change.)